DOCUMENT RESUME

ED 464 241 CE 083 201

| | |
|---|---|
| AUTHOR | Hart, Angie; Lockey, Rachael; Henwood, Flis; Pankhurst, Francesca; Hall, Valerie; Sommerville, Fiona |
| TITLE | Addressing Inequalities in Health: New Directions in Midwifery Education and Practice. Researching Professional Education Research Reports Series. |
| INSTITUTION | English National Board for Nursing, Midwifery and Health Visiting, London. |
| REPORT NO | ENB-RR-20 |
| ISBN | ISBN-1-901697-70-3 |
| PUB DATE | 2001-00-00 |
| NOTE | 228p.; For research highlights of this report, see CE 083 202. |
| AVAILABLE FROM | English National Board for Nursing, Midwifery and Health Visiting, Publications Department, Victory House, 170 Tottenham Court Road, London W1P OHA, England, United Kingdom. Tel: 0207-391-6314; e-mail: pubs@enb.org.uk. |
| PUB TYPE | Reports - Evaluative (142) |
| EDRS PRICE | EDRS Price MF01 Plus Postage. PC Not Available from EDRS. |
| DESCRIPTORS | Case Studies; Client Characteristics (Human Services); *Cross Cultural Training; Curriculum Development; Developed Nations; Disadvantaged; Educational Change; Educational Research; Foreign Countries; Health Occupations; Health Services; *Medical Education; *Minority Groups; National Surveys; *Obstetrics; Policy Formation; Program Effectiveness; Public Policy; *Social Attitudes |
| IDENTIFIERS | England; *Midwives; Reflective Practice |

ABSTRACT

This report addresses key questions concerning the effectiveness of midwifery education in preparing midwives to meet the needs of women from minority or disadvantaged groups in England. Chapter 1 sets out the methodological context within which the work was undertaken and provides an overview of data sources and sample sizes. Chapters 3 and 4 review relevant literature relating to the project, with Chapter 3 focusing on the conceptualization of issues of inequality and disadvantage and Chapter 4 concentrating on how health care policy approaches inequalities issues, midwifery policy, and education of health professionals. Chapter 5 presents findings of a national survey of pre- and post-registration midwifery education curricula relating to inequalities and disadvantage. Chapters 6-8 explore findings from studies of midwifery education and practice in three very different parts of England. They illustrate the reality of providing midwifery care to service users from a variety of socioeconomic and ethnic backgrounds and reflect on how education prepares midwives to meet the needs of these different service users. Chapter 9 adopts a developmental focus, considering the findings in light of potential changes to education and practice. It outlines an "inequalities imagination," a concept developed during the study, and offers midwives a way of critically thinking about inequalities issues by drawing on debates around anti-discriminatory, anti-oppressive, and reflective practice. (Contains 233 references.) (YLB)

Reproductions supplied by EDRS are the best that can be made
from the original document.

ED 464 241

# RESEARCHING PROFESSIONAL EDUCATION

## Addressing Inequalities in Health: new directions in midwifery education and practice

PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

2B

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

QUALITY EDUCATION · FOR QUALITY CARE ·
ENB

*research reports series*

*number 20*

BEST COPY AVAILABLE

English National Board for
Nursing, Midwifery and Health Visiting

QUALITY EDUCATION FOR QUALITY CARE
ENB

# RESEARCHING PROFESSIONAL EDUCATION

*A series from the English National Board for Nursing, Midwifery and Health Visiting*

# Addressing Inequalities in Health: new directions in midwifery education and practice

Angie Hart
Rachael Lockey
Flis Henwood
Francesca Pankhurst
Valerie Hall
Fiona Sommerville

London, 2001

Published by
The English National Board for Nursing, Midwifery and Health Visiting,
Victory House, 170 Tottenham Court Road, London W1T 7HA
Telephone: 020 7388 3131
Fax: 020 7383 4031
E-mail: pubs@enb.org.uk
www site: http://www.enb.org.uk

© English National Board for Nursing, Midwifery and Health Visiting, 2001

ISBN 1 901697 70 3

This report has been prepared for publication by
Jill Rogers Associates, Cambridgeshire
Design by Sadler, Suffolk
Printed by Piggott Printers Limited, Cambridge

All rights reserved. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic or mechanical, photocopying, recording and/or otherwise without the prior written permission of the publishers. This book may not be lent, resold, hired out or otherwise disposed of by way of trade in any form, binding or cover other than that in which it is published, without the prior consent of the publishers.

Copies of the research tools used in this study may be obtained from the authors:
Dr Angie Hart, Senior Lecturer, Institute of Nursing and Midwifery, Westlain House,
University of Brighton, Falmer, East Sussex BN1 9PH
Tel: 01273 644051 E-mail: a.hart@brighton.ac.uk

## Acknowledgements

Our thanks are due to the English National Board for Nursing, Midwifery and Health Visiting for commissioning this research. The Board's Assistant Director for Educational Policy, Dr Sonia Crow provided valuable help and advice throughout. We are grateful to the members of our Steering Group for their helpful comments on the draft of this report as well as for their help with the project design.

The secretarial support of Heather Young was invaluable to the project team. Sarah Gardner assisted with proof-reading the report. We also acknowledge the help and support of Professor Carolyn Miller, Dr Julie Scholes and Dr Marnie Freeman, at the Centre for Nursing and Midwifery Research, University of Brighton in preparing this document. Colleagues in the areas in which we conducted our research also commented on drafts of the report, although for reasons of anonymity we have not named them individually here.

In addition to those who directly commented on the content of this report, we acknowledge the contribution of others who helped with project design and/or content. We thank Debra Salmon, Euranis Neile and Professor Mavis Kirkham for suggesting additions to the project design and/or in identifying relevant literature sources. Ronan Foley provided the statistical information to help us decide where to base the case sites. Clarissa Little transcribed most of the interviews.

Finally, we are sincerely grateful for the co-operation we received from the midwifery community, health advocates and health service users. Midwifery educators painstakingly filled in our lengthy questionnaire and many other people, including students, midwives and their clients have been involved in meetings and interviews with us. At each of the case sites we were warmly welcomed and we are grateful to all our research participants for giving us their time and sharing their views with us.

## The Steering Group

Ranjini Beveridge, Health Policy Officer, Maternity Alliance

Jane Butler, Directorate Nurse and Midwifery Manager, Brighton Health Care NHS Trust

Dr Sonia Crow, Assistant Director for Educational Policy (R&D), English National Board for Nursing, Midwifery and Health Visiting

Meg Goodman, (Former) Health Policy Officer, Maternity Alliance

Dr Kate Gerrish, Reader in Nursing, Development and Practice, School of Nursing and Midwifery, University of Sheffield

Christine Hanson, User Representative, Brighton Oasis Project

Professor Sheila Hunt, Dean of Faculty, School of Nursing and Midwifery, University of Dundee

Andrea Mason, User Representative, City Gate Centre, Brighton

Noreen Morrin, Education Officer, Midwifery, English National Board for Nursing, Midwifery and Health Visiting

Professor Kate Robinson *(Chair)*, Senior Pro-Vice Chancellor, Faculty of Health Care and Social Studies, University of Luton

## The Authors

**Angie Hart** has a background in medical sociology and social anthropology with a specific interest in inequalities in health care provision. She is a principal lecturer undertaking research at the Centre for Nursing and Midwifery Research, University of Brighton, where she also teaches research and social aspects of caring to student nurses and midwives. Dr Hart has considerable experience of designing, supervising and executing evaluative research on health care issues using appropriate methodologies and working with a wide variety of groups. She has set up and managed complex research projects with large multidisciplinary teams, consistently working across the university-practice divide. Dr Hart has a long history of working collaboratively with a wide variety of research participants, including service users who are traditionally considered to be hard to reach. Her publications include work on prostitution and sexual health, evaluations of maternity services and mental health care provision to vulnerable children. She is currently working on a number of research studies including a Department of Health-funded project on social and cultural issues in the use of electronic patient records within the maternity services.

**Rachael Lockey** is a practising midwife and part-time research fellow. She has a background in anthropology, and an interest in women's health issues. Recently she has taken on the role of specialist midwife for women who are pregnant and using drugs. She has considerable experience of undertaking fieldwork and interviews, including on sensitive subject areas such as bereavement. Ms Lockey also has an interest in addressing inequalities in health in the practice setting, and has worked in the voluntary sector, including working for a Rape Crisis Project and a women's drug rehabilitation project.

**Flis Henwood** is a social scientist with an interest in questions of technology and inequality. Her research has focused on questions of gender equality in relation to technology in educational and work settings. Recent publications include a co-edited collection, *Technology and In/Equality: Questioning the information society* (Routledge, 2000). Her most recent research is concerned with information and communication technologies in health care. Together with Dr Angie Hart, she is working on two projects, the first concerned with the use of electronic patient records in maternity services, and the second examining health care consumers' use of the internet as a tool for accessing and managing health information.

**Francesca Pankhurst** has a background in psychology and sleep disturbance research, but her more recent work has been in relation to health services, particularly midwifery. She has been involved in two evaluations of new midwifery systems and a study of the impact of nurse-led drug administration. She is adept at employing both quantitative and qualitative methods and has worked with other health professionals and educationalists to increase their utilisation and dissemination of nursing and health-related research.

**Valerie Hall** has been a practising midwife for 21 years and is Deputy Head of the Institute for Nursing and Midwifery, University of Brighton where she is also an approved midwife teacher responsible for the academic and professional leadership of pre- and post-registration midwifery programmes. Committee work includes membership on University and Faculty Academic Standards Committees and the chairing of the Institute's Board of Study. Apart from chairing Institute Midwifery Exam Boards she is an external examiner to programmes in other universities. She is an ENB Specialist Registry member and has been an external member on programme validation panels. Over the past two years she has made a significant contribution to the work of the Quality Assurance Agency for Higher Education, both as a subject reviewer and as the co-ordinator of midwifery group benchmarking academic and practitioner standards. Midwifery publications include being an advisor to the Health Education Authority on the *New Pregnancy Book* and contributor to the 11th and 12th editions of *Myles Textbook for Midwives*. She recently submitted her doctoral thesis which examined the range and variety of learning experiences students use in order to become skilled midwives. She has a strong belief in the interdependence of theory and practice and is committed to the need to implement researched learning strategies which support this. Ms Hall teaches on a range of programmes utilising her midwifery, education and research knowledge.

**Fiona Sommerville** is the former Head of Midwifery Services at Brighton Health Care NHS Trust, where she successfully developed and implemented a strategy to establish Brighton's first patient-focused care centre. She has considerable experience as a respected supervisor of midwives and in assessing the impact of changes in service provision on users. She has a commitment to facilitating the development of midwifery practice within a multidisciplinary context. Ms Summerville has been Associate Editor (Midwifery) of *Nursing Times* since 1994. Recent publications include chapters relating to clinical midwifery practice in the Royal College of Midwives' publication *Every Body* and book reviews within *MIDIRS Digest* and the *Journal of Reproductive and Infant Psychology*. She has worked with Dr Hart and Ms Pankhurst during their evaluation of team midwifery and with Ms Hall collaborating on the delivery of pre-registration and continuing midwifery education. She currently works as an independent midwifery consultant.

## Abbreviations

| | |
|---|---|
| ADP | Anti-discriminatory practice |
| AMT | Approved midwife teacher |
| AOP | Anti-oppressive practice |
| ARM | Association of Radical Midwives |
| CCETSW | Central Council for Education and Training in Social Work |
| GHS | General Household Survey |
| GIS | Geographical Information Service |
| HSE | Health Study England |
| HALS | Health and Lifestyle Survey |
| NCT | National Childbirth Trust |
| PBL | Problem-based learning |
| RCM | Royal College of Midwives |
| SCBU | Special Care Baby Unit |
| UKCC | United Kingdom Central Council for Nursing, Midwifery and Health Visiting |

# *Foreword*

The English National Board for Nursing, Midwifery and Health Visiting is delighted to publish this report as the twentieth in its successful series: ***Researching Professional Education***.

The Board launched this series with the aim of making widely available the results and implications of research commissioned by the Board. The series enables key stakeholders: policy makers, managers, practitioners, researchers and educators to have access to relevant and sound research from which to plan educational developments.

Tackling health inequalities is firmly on the health agenda and this research addresses some of the key questions concerning the effectiveness of midwifery education in meeting the needs of disadvantaged clients. Among other methods the research team conducted in-depth case site interviews with student midwives, qualified midwives, educators and service users. These provide valuable insight into the perceptions of midwives and their clients.

This report has important implications, not only for the educational preparation of midwives, but also for other health professions in meeting the needs of disadvantaged clients. It is suggested that the developments be thought of, collectively, as initiatives that facilitate both students and qualified practitioners in developing an 'inequalities imagination'.

**Professor Ron De Witt**

Chairman, English National Board for Nursing, Midwifery and Health Visiting

**Professor Jeff Thompson**

Chair, Research and Development Committee, English National Board for
Nursing, Midwifery and Health Visiting

London, 2001

# Contents

**Glossary** 8

**1. Setting the Research Context** 9

1.1 Introduction 9
1.2 Evaluation aims 10
1.3 Evaluation questions 10
1.4 Background to the study 10
1.5 Organisation of the report 12

**2. Methodology** 13

2.1 Theoretical and methodological influences on the research process 13
2.2 Overview of the research undertaken 16
2.3 Consultation with groups 16
2.4 Literature review 17
2.5 National survey of pre- and post-registration midwifery education 17
2.6 Case site studies 20

**3. Defining Disadvantage, Conceptual Issues in the Health Care Context** 30

3.1 Introduction 30
3.2 Disadvantage: the sociological context 31
3.3 Disadvantage in health and social care: competing models 32
3.4 Framing midwives' perceptions of disadvantage 39
3.5 Conclusion 40

**4. Health Care Policy, Midwifery Practice and Educational Delivery** 41

4.1 Introduction 42
4.2 The broad health policy context 42
4.3 The midwifery policy context 43
4.4 The midwife's role 45
4.5 'Dos and don'ts': the practical focus of midwifery articles concerning caring for disadvantaged clients 48
4.6 Inequalities and the educational context 58
4.7 Conclusion 65

**5. Pre- and Post-registration Curricula Analysis** 66

5.1 Introduction to findings 66
5.2 Institutional arrangements regarding equal opportunities and anti-discriminatory practice 67
5.3 Contributors to curriculum planning and delivery 69
5.4 Curriculum philosophy, aims and learning outcomes 70
5.5 Key knowledge, skills and attitudes 75
5.6 Teaching content 76
5.7 Teaching strategies 79
5.8 Assessment 80

5.9 Practice placements as opportunities for learning about inequalities issues in pre-registration programmes 81
5.10 Provision of relevant post-registration education and factors affecting uptake 82
5.11 Validation of questionnaire data 84
5.12 Discussion 85
5.13 Conclusion 87

**6. Analysis of Case Site A 88**
6.1 Introduction and background to Case Site A 88
6.2 Curriculum analysis of Case Site A 90
6.3 Key themes and issues from the research data 92
6.4 Conclusion 120

**7. Analysis of Case Site B 121**
7.1 Introduction and background to Case Site B 121
7.2 Curriculum analysis of Case Site B 123
7.3 Key themes and issues from the research data 125
7.4 Conclusion 152

**8. Analysis of Case Site C 153**
8.1 Introduction and background to Case Site C 154
8.2 Curriculum analysis of Case Site C 156
8.3 Key themes and issues from the research data 158
8.4 Conclusion 187

**9. Conclusion and Developmental Implications 189**
9.1 Introduction 190
9.2 Developing an inequalities imagination: introducing the concept 190
9.3 Curriculum design and planning 196
9.4 Curriculum content 198
9.5 Methods of educational delivery 208
9.6 Assessment 210
9.7 Who delivers? 212
9.8 The way forward 213

**References 217**

**Figures**

4.1 A model of processes linking theory and practice 62
9.1 A model for developing an inequalities imagination 194

**Tables**

2.1 Data collection at Case Site A 21
2.2 Extra interviews at Case Site A 22
2.3 Data collection at Case Site B 22
2.4 Extra interviews at Case Site B 22
2.5 Data collection at Case Site C 23
2.6 Extra interviews at Case Site C 23
6.1 Data collated at Case Site A 92
7.1 Data collected at Case Site B 126
8.1 Data collated at Case Site C 158

BEST COPY AVAILABLE

## Glossary of Terms

**Educator:** To assist with the preservation of anonymity, we have used the terms educator, as a substitute for the job titles of individuals below the level of senior lecturer (old universities) or principal lecturer (new universities). Senior lecturers in old universities and principal lecturers in new universities are referred to as senior educators.

**Mentor:** As described in *Standards for Approval of Higher Education Institutions and Programmes* (ENB, 1997) a mentor is an individual who has an understanding of the context of the students' learning experience and is selected by the student for the purpose of providing guidance and support.

**Preceptor:** This term may be used in two ways. The first, in accordance with the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), refers to a qualified member of staff who undertakes support and guidance of a newly-qualified member of staff in the first six months of their practice. The second is more loosely used to denote an appropriately qualified member of staff who undertakes mentorship and assessment of pre-registration students. We note that this latter definition is not the formal definition of the UKCC, but its use is based on the terms used by research participants.

**Senior educator:** To assist with the preservation of anonymity, we have used the term senior educator as a substitute for individuals above the level of senior lecturer (new universities) or lecturer (old universities).

**Service user:** Rather than client, this more neutral term has been our preferred term throughout the report. However, for stylistic reasons we have occasionally used the term client.

**Students:** We use the term student in its broadest sense, taking into account the philosophy of lifelong learning and the fact that all midwives and those in midwifery education and management are required to maintain their registration through updating. Thus we include pre-registration and post-registration students within the term.

## 1.1 Introduction

We have come a long way from the days when differences between the health outcomes of the rich and poor in the UK were largely described in policy documents as 'variations' (Benzeval et al., 1995). Furthermore, controversy surrounding whether or not health inequalities exist has been largely superseded by attempts to document their precise composition and causality (Bartley et al., 1998; Wilkinson, 1997). Policy initiatives have been introduced which prioritise the health needs of women of childbearing age and young children, providing mandates for ameliorating health inequalities and reorganising services. Central tenets of these initiatives include:

- nursing within primary care and midwifery care should largely be targeted towards disadvantaged clients (DoH, 1998a; 1999a)
- midwives will develop their role in public health and family wellbeing (DoH, 2000a)
- health and social services should be structured in a manner which reflects 'joined up' thinking (Hunter, 1998)
- specific projects should address health, educational and social inequalities in areas of high socio-economic deprivation (DoH, 1998b).

More broadly, central Government has affirmed its commitment to increasing NHS funding, and has begun to challenge the traditional hierarchies that exist between health professionals and service users (DoH, 2000a). Furthermore, through expanding the roles of nurses and midwives and introducing processes such as clinical governance, which potentially promote increased public accountability of doctors, traditional professional hierarchies may also be challenged (DoH, 1999b). However, only time will tell whether any of these initiatives will result in positive health outcomes.

Furthermore, it is imperative that anticipated gains made by the introduction of new policies are not lost through lack of forethought about their operationalisation. Thus the development of organisational cultures which facilitate the promotion of practice targeted at disadvantaged clients is important, as is consideration of what actually occurs during interactions between health professionals and their clients. For the aims of policy initiatives to be realised, health professionals need to work with disadvantaged service users in ways that facilitate health benefits. Many will testify to the positive way in which health professionals work, often in stressful and under-resourced contexts, to achieve this. However, there are as many examples of how interactions between health professionals, health care institutions and service users result in clients feeling oppressed and humiliated, rather than cared for – particularly in the case of disadvantaged service users.

There are many complex debates behind these issues, with resourcing, politics and culture, gender, sexuality, disability, ethnicity and class at the fore. However, ensuring that health professionals work with disadvantaged clients in a manner which takes account of differences in background and lifestyle, respects human rights and promotes human dignity is vital in realising the vision inherent in the policies outlined above. Reviewing, and, if necessary, changing, the way in which health professionals are prepared for practice is an important step towards realising these broad policy visions.

Within this context of rapid change in attempts to deal with health inequalities, and issues of power and control within the NHS and related public institutions, this study was commissioned by the English National Board for Nursing, Midwifery and Health Visiting

11

(the Board). The project was referred to during the research process as The RESPECT project (Research into midwifery education and services *promoting* equality of care to all women).

## 1.2 Evaluation aims

The original aims of the project were:

1. to undertake an extensive literature review
2. to analyse and evaluate curricula learning outcomes, teaching and assessment methods in relation to the care provided to minority or disadvantaged groups
3. to evaluate the appropriateness of stated learning outcomes in relation to the skills and abilities that midwives need to assess and provide for women from a range of minority or disadvantaged groups.
4. to advise the Board on ways in which educational preparation could most effectively enable the assessment, provision and evaluation of the maternity needs of all women.

## 1.3 Evaluation questions

In addition to the original proposal we proposed a number of evaluation questions pertinent to the issues being addressed, in order to translate the Board's broad aims into more specific questions, which could provide a framework for the research:

1. What is the current picture in the literature regarding the provision of maternity care to minority or disadvantaged women, with regard to historical, social and political contexts in relation to concepts such as 'impairment', 'prejudice' and 'discrimination'?
2. What is the key knowledge and what are the key skills and abilities identified in the literature which are needed by midwives in order to execute anti-discriminatory practice, and to care effectively for disadvantaged women or women from minority groups?
3. What is the degree of consensus articulated by representatives of different stakeholders (e.g. midwives, clients, managers, educationalists) in relation to the knowledge, skills and abilities needed by midwives to facilitate equal opportunity of care for minority or disadvantaged women?
4. How effective are midwives in working as part of a multiprofessional team in relation to addressing the needs of disadvantaged women?
5. How close is the match between theoretical educational provision and the realities of practice in preparing midwives with the knowledge, skills and abilities to meet the needs of minority and disadvantaged women?
6. In what ways are pre-registration and post-registration curricula preparing midwives to meet the needs of minority and disadvantaged women? What are the similarities and differences in approach in terms of outcomes, teaching and assessment?
7. What is the congruence between the literature, educational curricula and stakeholders in relation to the key knowledge, skills and abilities needed by midwives to meet the needs of minority and disadvantaged women?
8. In what ways can educational preparation for practice most effectively enable the assessment, provision and evaluation of maternity needs of all women, irrespective of their differing contexts and backgrounds?

## 1.4 Background to the study

As stated above, this project was undertaken within a political climate in which the amelioration of social, economic and health inequalities is firmly on the agenda. Considerable interest in issues of disadvantage and inequalities in health has been generated at the levels of both policy and practice in the NHS. Thus, along with other health specialisms, there is a growing concern within midwifery about the care provided to disadvantaged women. *Changing Childbirth* (DoH, 1993) was influential in making midwifery care both more midwifery-led and focused on meeting consumers' needs. However, it has become clear that the needs of disadvantaged women warrant specific attention.

The increasing body of work on psychosocial aspects of health inequalities, including the concept of 'social capital' (Wilkinson, 1996) and its effects on health, are evidence of how important it is for disadvantaged women to have the best possible care. Davies (2000) reports that if disadvantaged women do not feel supported during childbirth, this can be compounded by already low levels of self-esteem. Poor self-esteem has been shown to negatively affect health and an individual's ability to bring up children (Bartley et al., 1998; Cunningham and Henggeler, 1991). Also, women on low incomes tend to have low-birth weight babies, itself an indicator of poor health outcomes. Low levels of breast-feeding amongst these women can also contribute to health problems for both babies and mothers (Graham, 2000).

There is already evidence to suggest that midwives do not feel equipped to play an effective role in reducing health inequalities. Pope et al. (1998a) explored how confident midwives felt about providing care to women from a range of social and cultural backgrounds, and support on social and welfare issues; they received a mixed response. Most midwives surveyed felt confident to meet the needs of individuals from a range of social backgrounds. However, less than half felt confident or very confident about meeting the needs of individuals from a range of cultural backgrounds. Community midwives felt most confident in providing women with information on social or welfare issues, or to refer as appropriate (Pope et al., 1998b). Amongst hospital midwives and those working between hospital and community, G grades were more confident at providing information regarding social and welfare issues than colleagues on lower grades. Although there is currently much of merit occurring within midwifery, the study reported here demonstrates how midwives might become better prepared to meet the needs of disadvantaged clients.

Whilst current Government policies only address implicitly how health professionals might best practise in their day-to-day dealings with disadvantaged service users, these topics have been addressed in other work commissioned by the Board. This project builds on research already undertaken, in which attitudes and communication are given considerable attention. For example, Gerrish et al. (1996) explored the preparation of nurses and midwives for working within multi-ethnic Britain. Many other issues raised in their research are pertinent to this study. In particular:

- the paucity of appropriate education in relation to minority ethnic issues in nursing and (to a lesser extent) midwifery curricula
- the complex nature of the relationship between curriculum content and student learning in practice settings and its connection to the user perspective
- the significance of social, legal, economic and political contexts in relation to the health needs of ethnic minorities
- the relevance of both education and service organisation and management structures in shaping students' learning experiences
- issues associated with students learning to care for women whose needs they have encountered only in the classroom, and not in practice settings
- the importance of analysing curricula across Britain to establish a broad perspective followed by in-depth studies which explore dynamic nuances in context
- the relevance of the personal and professional biographies of both staff and students in shaping learning, and the different ways in which students and health professionals can learn from each other.

The Board has commissioned other research which has broad relevance to our study. Research by Pope et al. into the role of the practising midwife and her continuing education needs raises many issues which are relevant to our research (Pope et al., 1996; 1997; 1998a; 1998b; 1998c; 1998d). Their work raised important questions about the boundaries of the midwives' role as well as the type of care they feel confident to give, and these have informed this study.

Finally, Fraser et al. (1998) raised a number of issues which have broad relevance here:

- the need for a greater integration of theory and practice
- the importance of appropriate training and monitoring for practice assessors of students
- the need for a more uniform approach to the provision of learning opportunities.

Such educational research projects take place against a backdrop of changes within higher education. Increasing student numbers, problems with retention and recruitment and increasing demands on educators to demonstrate effectiveness all impact on the potential to develop learning and teaching about the needs of disadvantaged clients.

## 1.5 Organisation of the report

Evaluating the effectiveness of midwifery education in preparing midwives to meet the needs of women from minority or disadvantaged groups is complex. The definition of 'disadvantaged' is itself a difficult issue which must be explored within an appropriate historical, social and political context, before an informed approach can be taken to the evaluation; this is discussed in Chapter 3. However, Chapter 2 first sets out the methodological context within which the work was undertaken and provides an overview of the data sources and sample sizes. Chapters 3 and 4 review relevant literature relating to the project, the former focusing on the conceptualisation of issues of inequality and disadvantage, and the latter concentrating more specifically on how inequalities issues are approached in health care policy, midwifery policy and the education of health professionals.

Chapter 5 presents the findings of a national survey of pre- and post-registration midwifery educational relating to inequalities and disadvantage. Chapters 6, 7 and 8 explore the findings from studies of midwifery education and practice in three very different parts of England. These chapters give an indication of the reality of providing midwifery care to service users from a variety of socio-economic and ethnic backgrounds, and reflect on how midwives are prepared through education to meet the needs of these different service users.

Chapter 9 adopts a developmental focus, considering the overall findings in the light of potential changes to education and practice. It outlines a concept which developed in the process of this study; this concept is referred to as an 'inequalities imagination', and offers midwives a way of critically thinking about inequalities issues, drawing on debates around anti-discriminatory, anti-oppressive and reflective practice. The report concludes that although there is currently much on offer within midwifery education which helps to prepare midwives to meet the needs of disadvantaged clients, there is considerable scope for development. It is suggested that midwifery curricula, and those of other health professions, could benefit from explicitly framing preparation 'to meet the needs of disadvantaged groups' in accordance with the concept of an 'inequalities imagination'.

### Key Points

- This chapter begins by discussing the theoretical and methodological influences on the study. The main influences were critical realism, grounded theory, and reflexivity.
- The need to arrive at working definitions of the concepts of 'disadvantage' and 'needs' within a midwifery context was imperative. This was achieved using a grounded-theory approach to explore participants' own meaning of the terms.
- The researchers carried out a detailed literature review prior to empirical data collection.
- Critical realist ideas informed the methodological approach. The researchers were concerned to identify and discuss the 'real-world customs and practices', which emerged out of the social meanings and interactions which constituted contemporary midwifery education and practice.
- The research team was aware that they, as individual researchers, were playing an active role within the research process. It was therefore important that they reflected explicitly on their own values and practices within the work.
- The team comprised six individuals, each with their own prior assumptions, personal and professional backgrounds; three were midwives, and three not. Working as a team resulted in benefits, such as a broadened research skill base, as well as a higher level of conceptual thinking. The administration of the project was, however, made more complex as a result of such teamwork.
- In the early stage of the project, consultation occurred with relevant professional bodies, user groups and key individuals. Relevant conferences were attended, and networking was done on a wide basis.
- A national survey of contemporary midwifery education was undertaken, via a questionnaire. Forty-six education departments were invited to complete the questionnaires; there was a 54% response rate to the pre-registration questionnaires, and a 39% response rate to the post-registration questionnaire.
- In order to explore, in greater depth, the links between curriculum, theory and practice, three case sites were investigated. These were chosen using deprivation indices, with the need for a geographical spread borne in mind. Size of the education department was also taken into consideration.
- Three months of fieldwork were undertaken at each site. This comprised: interviews with midwifery educators, managers, students, midwives, and service users; focus groups; observations of classroom sessions. In total, 264 hours of data were collected. Informed consent was sought, and confidentiality assured.

## 2.1 Theoretical and methodological influences on the research process

The original brief from the Board asked for 'consideration of the effectiveness of midwifery education in meeting the needs of disadvantaged clients'. Embedded within this is a complex set of issues. In particular, two key questions needed to be answered before the research could begin:

- How should we define 'disadvantage'?
- How should we define 'needs' in this context?

There were no clear-cut answers to these questions, and we could not simply select a working definition and move on to adopt or design a methodology. It was decided that a

15

central concern of the research should be to develop greater insights into definitions of 'disadvantage' and 'needs' within midwifery education and practice. A methodology was sought that would enable us to create a 'window' into midwifery education and practice to see these definitions at work, to try to elucidate the different meanings and assess their implications for practice.

Thus the methodological approach drew broadly on grounded theory, with its emphasis on developing interpretations from the data, rather than testing any prior hypothesis (Glaser and Strauss, 1965). However, contrary to research which is wholly embedded within grounded theory, a detailed literature search was undertaken prior to data collection, making us conversant with many ways in which issues of disadvantage were addressed in midwifery and the social sciences. Some members of the research team already had wide knowledge of debates about health inequalities. We explicitly attempted to be aware of how their prior research and reading influenced the issues highlighted. Thus, whilst the formats of the questionnaire, interviews and observations in the case sites were influenced by prior knowledge and understandings, there was a conscious effort to allow informants' own perceptions to emerge.

In order to address the relationship between meaning and practice, a 'critical realist' framework was adopted for the methodology. This is broadly in sympathy with phenomenological approaches but, unlike phenomenological approaches, realist evaluation explicitly acknowledges the reality of a world 'out there':

> *'... evaluation deals with the real. Let us think of some examples ... We believe that burglars are real, so are prisons, and so are the programs which seek to reduce burglary and rehabilitate prisoners and so too are the successes or failures of such initiatives. We do not accept that such components of the criminal justice system take their meaning narratively according to the political rhetoric and legal discourse which surrounds the key players. In making such a claim, we do not suppose that the examples mentioned above correspond to some elemental, self-explanatory level of social reality which can be grasped, measured and evaluated in some self-evident way ... All social interaction creates interdependencies and these interdependencies develop into real-world customs and practices, which are quite often independent of how people would wish them to be. These emergent processes are the realities which social programs seek to change. These are the realities assumed in our approach, which always begins with an attempt to come to a sociological understanding of the balance of resources and choices available to all participants involved in a program.'*
>
> (Pawson and Tilley, 1997: xiii)

This research is, then, an evaluation in the sense understood by Pawson and Tilley (1997). In attempting to evaluate the effectiveness of midwifery education in meeting the needs of disadvantaged clients, we wanted to identify and discuss the 'real-world customs and practices' which emerge from the social meanings and interactions which constitute contemporary midwifery education and practice.

In the original research proposal, the nascent critical realist perspective could be seen. The proposal highlighted the reality of structural socio-economic deprivation, yet stressed the importance of understanding both professional and lay identity constructions, and the struggles that take place in relation to the 'naming' and 'owning' of disadvantage and special needs. The fact that midwives and nurses must accomplish professional tasks within a material or 'real' world led us to accept the critical realist position. Nevertheless, the way in which people perceive this reality differs widely. Furthermore, whilst we endeavoured to work within a framework which allows informants' different perceptions to emerge, our own perceptions do not sit outside cultural and social processes.

Within social sciences, the importance of developing reflexive accounts of the power relationships between researcher and researched has long been recognised (Hart, 1998). The grounded theory tradition maintains that the researcher's role is as an interpreter, and explains the importance of researchers' reflexivity in relation to data collection and analysis. Maynard goes so far as to suggest that *'the researcher is also a subject in her research'* (Maynard, 1994: 16), highlighting the need for researchers to clarify any assumptions they build into the research and recognise that their personal histories affect the research process and its outcome. In our research, midwives and students were asked to reflect on the degree to which they were meeting the needs of disadvantaged service clients, and about their own values and practices concerning this issue. It is, therefore, important to reflect explicitly on these issues in relation to our own work and our research and personal selves. As with interviewees in social research, we too have an interest in constructing positive identities for ourselves, particularly in defending our professional standings. It is worth noting, therefore, that, as with the accounts of interviewees, reflexive accounts of research processes are, on one level, narrative constructs and can be regarded as somewhere on a continuum between 'veridical accounts' and 'rhetoric' (Sapsford and Abbott, 1998). As Barbour notes:

> *'The "knowledge" which we derive from our research is ... the result of a process of social construction in which we as researchers play an active role.'*
> (Barbour, 1998: 183)

These issues are particularly complex when considering research conducted by multidisciplinary research teams. Whilst there is a growing literature on such research (e.g. Richards, 1999; Tishelman et al., 1999), little social scientific work on reflexivity has discussed it; exceptions include Barry et al. (1999). Most accounts continue to portray the researcher as working alone, with only one person's prior assumptions and personal history to take into account.

Tripp-Reimer et al. (1994) hint at some pitfalls involved in multidisciplinary teamwork, arguing that:

> *'The dialectic of collaborative research is that it is at once the most exciting and most difficult scientific path one can walk. On one side, uniquely innovative ideas are synthesised and fresh insights into the world emerge. On the other side, conflict and frustration result from the clash of strong wills, competing ideologies and imperfect theoretical frameworks for the problems at hand ... The challenge is for the teams to stay together long enough for the team to grow.'* (Tripp-Reimer et al., 1994: 318)

Whilst our experience of teamwork was not as difficult and dramatic as those of Tripp-Reimer and colleagues, the team comprised six people, each with their own prior assumptions, personal and professional backgrounds. The degree and manner to which each individual contributed to the project differed. However, the advantages of teamwork certainly outweighed the disadvantages. In particular, it broadened the research skills basis as well the higher level of conceptual thinking that can be fostered through teamwork (Barry et al., 1999). The fact that the team comprised both midwives and those without a midwifery background was a further benefit. The main disadvantages were that a large team was administratively complex, and procedures often took longer than if only one person was undertaking the research.

The study's project manager was used to undertaking research in which she became an honorary member of a wide range of subcultures (Hart, 1998) including prostitutes, nuns, doctors and midwives (e.g. Hart, 1998; Hart et al., 1999; Hart and Pankhurst, 1998). Anthropological monographs are replete with discussions concerning the negotiation of the identity of the researcher in the field. In some non-western contexts female researchers who become 'honorary men' may not enjoy the access to indigenous women that they might have done had they entered the field through a route which did not follow official lines of power.

This is also the case in relation to this project. Access routes in each field site was according to a top-down model, since discussions about access began with midwifery managers. Furthermore, the main field researcher was a midwife herself. While facilitating access to the subculture of midwifery, this also embedded the research more fully within that subculture.

The point here is that our relationship to the lives, identities and stories of women clients was partially set up so that they would perceive us (quite correctly) as 'sort of professionals'. This was despite our claims to be in some ways experiencing some of the disadvantages highlighted in the study. This is an important issue to bear in mind when considering the data and interpretations. Had the project begun at the 'grass roots' and worked 'up', the findings may, in some respects, have been different.

Despite the issues raised above, the approach taken to accessing the views of service users did facilitate the collection of a wide data set.

## 2.2 Overview of the research undertaken

The first year of the project focused on:

- literature review and reflection on the methodological and theoretical focus of the research
- design, distribution and data entry of questionnaires for curriculum analysis and requests for a sample of curriculum documents
- case site selection, preliminary meetings and ethics approval applications
- meetings with key midwifery organisations and user groups
- development of information sheets and interview schedules
- piloting of information sheets and interview schedules with local midwives, students, lecturers and service users
- undertaking of fieldwork in the first case site.

The second year focused on:

- undertaking of fieldwork for the second and third case sites
- writing up the data from the case sites
- undertaking further curriculum analysis.

## 2.3 Consultation with groups

We felt that it was important to discuss the project with relevant professional bodies, user groups and individuals. The following were consulted, and their advice contributed to the ongoing research process:

- Maternity Alliance
- Disability, Pregnancy and Parenthood International
- Royal College of Midwives
- Royal College of Midwives student representatives
- Royal College of Midwives student conference
- specialist midwives
- experts in fields of research with people with learning difficulties
- an educational expert in the cultural context of childbirth
- other researchers carrying out related projects.

In addition, we attended relevant conferences and networked widely.

## 2.4 Literature review

The literature review (Chapters 3 and 4) focused mainly on issues relating directly to the midwifery literature regarding women with specific needs/disadvantaged women. It set the literature in the context of contemporary social policy relating to initiatives targeting health care for socially excluded people. Furthermore, the review considered the role of the midwife in the context of the roles of other health and social care practitioners. The manner in which the literature constructs the major issues and implications for practice which come about as a result of working with disadvantaged service users was drawn out, and relevant social work literature related to equal opportunities and anti-discriminatory practice (ADP) issues explored.

The literature review informed both the development of a preliminary framework for the analysis of curriculum documentation and identification of possible case studies.

The literature search was undertaken using the major relevant databases, and was complemented by a hand search of the main midwifery literature. The literature was skimmed to give a broad overview, then a more detailed review was undertaken of the following:

- the extent to which midwives work with disadvantaged service users
- the historical, social and political contexts of minority and disadvantaged women
- identification of key knowledge, skills and abilities important for midwives to care for disadvantaged women
- management of midwifery services in relation to special needs and woman-centred care
- the impact of *Changing Childbirth* (DoH, 1993)
- changes in midwifery education
- educational materials available to midwives, regarding teaching related to disadvantage.

The knowledge, skills and abilities identified were organised into logical groupings which contributed to the development of a framework for analysis of the curriculum documentation and case site data.

## 2.5 National survey of pre- and post-registration midwifery education

Following the literature review, a national survey of midwifery education was undertaken to gauge the extent to which it was preparing midwives to identify and meet the needs of women who may experience inequalities in health or health care provision.

Questionnaires were distributed to midwifery programme co-ordinators who were asked to comment on key aspects of the curriculum and its implementation. These data were then complemented by documentary analysis of a smaller sub-sample of curriculum documents.

This method enabled the team to explore the relationship between curriculum documentation, learning outcomes and programme delivery on a national scale. In particular, the questionnaires to programme co-ordinators provided insight not only into what appeared in the programme curriculum documentation, but also into how co-ordinators experienced the implementation of those curricula. Programme co-ordinators were given the opportunity to report on specific challenges or innovations associated with their programmes which were relevant to the research but not yet recorded in curriculum documentation. Questions were also asked about the institutional context within which curricula were delivered, such as the ethos of the department or educational institution in terms of equal opportunities and ADP, and opportunities for raising awareness of these issues for staff and students.

### 2.5.1 Questionnaire design

Two questionnaires were developed: one for pre-registration and one for post-registration midwifery education. Both were shaped by insights gained from:

- the literature review
- interviews with midwifery educators in the University of Brighton
- interviews with a sample of midwifery educators in England
- interviews with students to discuss questionnaire design
- meetings with midwifery organisations and user groups.

The questionnaires were piloted by telephone interview with midwifery educators from 10 educational institutions, and amended as a result of the pilot interviews. The questionnaires were sent with an explanatory letter, and both were prefaced with an explanation of the focus of the questionnaire, as follows:

> *'The focus of this questionnaire is on preparing midwives to provide equality of care and equal access to service for all women. In particular, we want to find out how your curriculum covers inequalities in health and potential inequalities in healthcare provision. We have deliberately not been too specific about the meaning of these terms, as we want to know how your curriculum approaches this broad area.'*

Some respondents had difficulties with these terms and were not sure what they meant. During the pilot phase of the questionnaire, we had become aware that there would be difficulty with any one term including 'disadvantage', 'vulnerable groups', 'equal access' etc., as different institutions used different terms. Therefore, a broad term was used with some guidance as to the sort of issues we were interested in. While some educators were still confused about what we were asking, the data we have collated demonstrated that most had a sufficient understanding.

The aim of the pre-registration questionnaire was to collect information on one particular pre-registration midwifery programme at each midwifery educational institution in England. Where institutions ran more than one curriculum (for example an 18-month and a three-year programme), respondents were asked to focus on the most recent one. The pre-registration questionnaire asked respondents to identify:

- relevant content in teaching sessions, units or modules
- relevant learning outcomes
- contributors to teaching in this subject area (both within and outside the midwifery department)
- service users whose needs were, and those whose needs were not, addressed in the curriculum
- relevant practice- and theory-based assessments
- relevant knowledge, skills and attitudes
- details of practice placements and opportunities for students
- relevant staff development for lecturers
- policies and forums regarding equal opportunities and ADP
- relevant reading lists.

The aim of the post-registration questionnaire was to gain broad insight into the teaching of inequalities in health and health care provision to midwifery students. Respondents were asked to identify:

- relevant continuing education offered
- relevant learning outcomes and assessment
- relevant reading lists
- relevant staff development
- the decision-making process for content and type of post-basic education provision
- local support for negotiating time off and finance for post-registration education.
- other local post-registration education opportunities
- areas which were adequately addressed in post-registration education and those which were not.

### 2.5.2 Questionnaire distribution and returns

A total of 46 midwifery education departments were invited to complete a pre-registration and a post-registration questionnaire. These were sent to the approved midwife teacher (AMT) at each institution in December 1998, with a request for returns by the end of January 1999. The AMTs had the option of completing the questionnaires themselves or passing them to appropriate colleagues. Reminder letters were sent in mid-January and follow-up telephone calls were made after the deadline to encourage as full a response as possible.

Although 27 institutions returned questionnaires, a response rate of 59%, not all returned both questionnaires. A total of 25 pre-registration questionnaires were returned, a response rate of 54% for the pre-registration survey. Eighteen post-registration questionnaires were returned, a response rate of 39%.

### 2.5.3 Analysis of curriculum documents

A sample of curriculum documents was also obtained for triangulation purposes from nine institutions, including the three case sites. Given the breadth of the questionnaire and the extent of the detail which lecturers incorporated into their answers, it was agreed that, for the non-case study sites, the triangulation of curriculum documentation be limited to a review of learning outcomes only. The results of this exercise are reported in Chapter 5.

More detailed analyses of the curriculum documents pertaining to the case sites were undertaken and are reported in the case study chapters. However, it is interesting to note here that in all three analyses, a comparison of questionnaire responses and detailed documentary analysis suggests that there may have been some under-reporting of coverage of inequalities issues. For example, some documentation contained statements that appeared to have clear relevance to the issue of inequalities and yet these statements had not been selected for inclusion in the completed questionnaires.

### 2.5.4 Questionnaire analysis

All the data generated by the questionnaires were entered into Non-numerical Unstructured Data Indexing Searching and Theory building for qualitative analysis and Statistical Package for the Social Sciences for quantitative analysis. Descriptive statistics were generated and the qualitative material was analysed thematically in accordance with standard methods of analysing qualitative data which draw on grounded theory approaches (Glaser and Strauss, 1965). The results of the pre- and post-registration questionnaires are reported in Chapter 5.

## 2.6 Case site studies

### 2.6.1 The case site study method

To explore in greater depth the links between curriculum, theory and practice it was decided to undertake more detailed exploration of educational delivery and midwifery practice in three different geographical contexts, referred to as 'case sites'.

The case site evaluation draws on both case study and stakeholder evaluation methods. The case study can enable researchers to explore broad, complex questions in complex circumstances, making it ideally suited to this type of project (Simons, 1980; Keen and Packwood, 1995). The stakeholder evaluation enables researchers to incorporate a broad range of perspectives into the research design, execution and analysis and is useful for constructing chains of evidence, comparing the perspectives of individual stakeholders in relation to the same issue. It is also helpful in investigating causation in complex environments (Stake, 1979; Smith and Cantley, 1985).

Whilst the study benefited from the inclusion of a range of stakeholders within each site, and from an exploration of work in both university and practice settings, there were some limitations to the use of the case study method.

One important limitation concerns the formation of chains of evidence. The research certainly generated a large quantity of data which specifically related to other data collated. For example, direct comparisons could be made between what specific students and their midwifery preceptors said about specific clients. However, we were unable to generate data which developed specific chains of evidence. Time constraints precluded spending more than three months in each case site. It was simply not possible to capture specifically, and sequentially, the relationship between what occurred in the university setting in terms of teaching and learning on inequalities and what happened in the practice setting, and *vice versa*. To capture these phenomena would have required a longitudinal study which followed student cohorts from the beginning of their programme to their early years as qualified midwives.

Since research was undertaken in both university and midwifery practice settings in each study site there are, in effect, six mini-case studies. This report employs the term 'case site' due to the relatively brief time spent in each location, coupled with the fact that the research was, in effect spread over six sites. The term 'case study' might imply tighter research data sets than those generated.

### 2.6.2 Case site selection

A Geographical Information System (GIS) was used to help identify suitable areas for the case site research. The methods used are broadly similar to those used in the derivation of Jarman indices and other associated measures of deprivation (Carstairs, 1991; Folwell, 1995). Essentially these identify a series of appropriate variables/indicators of disadvantage such as high unemployment, high proportions of ethnic population, poor housing and low social class and combine them to produce a final score.

The raw data used to calculate this score included the 1991 census, with updated estimates from 1997, and other key variables such as ethnicity, unemployment, social class, housing tenure, age, dependency and limiting long-term illness. Additional data sources included surveys such as the Health Study England (HSE), Health and Lifestyle Survey (HALS) and the General Household Survey (GHS) as well as summary sources such as *Regional Trends* and specialist data from organisations concerned with disadvantaged groups.

The data were entered into the GIS and mapped to identify areas with particularly high scores. This was overlaid with a map of the main midwifery programmes and a spatial match was produced which gave a clear idea of potential case sites.

In conjunction with the deprivation indices, sites were selected to represent a geographical spread across England. Sites selected had either pockets of deprivation in otherwise affluent areas or large percentages of the population defined as socio-economically deprived. Of further consideration was the size of the midwifery education department, since the team wanted to obtain data from different sized institutions. Three sites were selected:

- Case Site A, with relatively low levels of social deprivation and a small midwifery education department
- Case Site B with relatively high levels of social deprivation and a large midwifery education department
- Case Site C with high levels of social deprivation, a large ethnic minority population and a medium sized midwifery education department.

### 2.6.3 Fieldwork in the case sites

Fieldwork was undertaken in both the midwifery education department and with the local midwifery service, in both the community and the hospital. The fieldwork for Case Sites A, B and C took place from May to August 1999, September to December 1999 and January to May 2000, respectively. Data sources included interviews, observation and focus group discussions.

Data collection was not always straightforward. Setting up interviews proved time-consuming, particularly where service users had learning difficulties, unstructured lifestyles, mental health or drug addiction problems, and/or had no telephone. Some educators and midwives were reluctant to be interviewed; others agreed readily but persistently cancelled meetings. In part, for service users, educators and midwives, this is a reflection of time and resource pressures, but may also have indicated passive resistance to the interview process. Other researchers have found this, particularly where interviewees perceive a power imbalance between them and the interviewer (Lee, 1993).

The most challenging site in terms of data collection was Case Site C, where several factors meant the fieldwork took longer than expected. In particular, the distance between the hospital and university made it difficult to arrange interviews on both sites in the same day. Furthermore, for many service user interviews, it was necessary to work with a bilingual advocate, which required more time both to set up and to undertake.

The following tables summarise the data collection target, as set out in the original project proposal, data collection achieved and the numbers of hours of interviewing obtained at each individual case site:

| Data | Target number | Number achieved | Hours of interview |
|---|---|---|---|
| Focus group with midwifery students | 1 | 1 | 2 |
| Interviews with midwifery students | 5 | 5 | 9 |
| Interviews with preceptors | 5 | 5 | 11 |
| Interviews with service users | 15 | 16 | 30 |
| Interviews with midwifery service managers | 2 | 2 | 3 |
| Interviews with midwifery tutors | 2 | 2 | 3 |
| **Total** | **30** | **31** | **58** |

Table 2.1: Data collection at Case Site A

| Data | Number achieved | Hours of interview |
|---|---|---|
| Parentcraft 'sisters' | 1 | 1 |
| Recently qualified midwife | 1 | 1 |
| Preceptor's student | 1 | 1 |
| **Total** | 3 | 3 |

Table 2.2: Extra interviews at Case Site A

In total, 34 interviews were conducted within a total of 61 hours at Case Site A. The researcher also undertook 18 hours of classroom observation and 29 hours of informal observation in the practice environment, including four visits to a venue offering specialist provision for young mothers.

| Data | Target number | Number achieved | Hours of interview |
|---|---|---|---|
| Focus group with midwifery students | 1 | 1 | 2 |
| Interviews with midwifery students | 5 | 5 | 7 |
| Interviews with preceptors | 5 | 5 | 9 |
| Interviews with service users | 15 | 16 | 21 |
| Interviews with midwifery service managers | 2 | 2 | 4 |
| Interviews with midwifery tutors | 2 | 4 | 8 |
| **Total** | 30 | 33 | 51 |

Table 2.3: Data collection at Case Site B

| Data | Number achieved | Hours of interview |
|---|---|---|
| Maternity link workers | 1 | 1 |

Table 2.4: Extra interviews at Case Site B

In total, 33 interviews were conducted within 52 hours. The researcher also undertook 18 hours of classroom observation, a further 10 hours of informal observation in the practice environment and a visit to a support group for younger mothers.

| Data | Target number | Number achieved | Hours of interview |
|---|---|---|---|
| Focus group with midwifery students | 1 | 1 | 2 |
| Interviews with midwifery students | 5 | 5 | 6 |
| Interviews with preceptors | 5 | 6 | 9 |
| Interviews with service users | 15 | 15 | 18 |
| Interviews with midwifery service managers | 2 | 3 | 4 |
| Interviews with midwifery tutors | 2 | 3 | 5 |
| **Total** | 30 | 33 | 44 |

Table 2.5: Data collection at Case Site C

| Data | Number achieved | Hours of interview |
|---|---|---|
| Health advocates | 5 | 7 |

Table 2.6: Extra interviews at Case Site C

In total, 38 interviews were conducted within 51 hours. The researcher also undertook 15 hours of classroom observation and 10 hours of informal observation in the practice environment.

In total, 264 hours of data collection were undertaken across the three case sites.

## 2.6.4 Issues of access

### 2.6.4.1 Access to sites

Access to both educational and clinical sites/contexts was sought in each case site. Exploratory discussions were held with senior midwifery staff in each of the three sites on both the education and service sides to secure their general agreement. Other members of staff were then invited to a presentation by the research team, at which the aims and objectives of the research, the methods to be used and the arrangements for ensuring anonymity were outlined. In Case Site A, access was only agreed once all staff concerned had listened to the presentation and had a chance to ask questions of the research team. In Case Sites B and C, access was granted following discussions with senior staff, although the research plans were presented to other members of the departments prior to the fieldwork. Despite the 'top-down' approach employed in this study, the team consulted a number of national groups representing the interests of service users and carried out pilot interviews with local users to develop this part of the evaluation.

### 2.6.4.2 Access to individuals

In all cases, assurances were given that individuals' participation in the project was entirely voluntary. There was a general willingness to participate, on both the education and service sides, although as stated above, this did not always translate into interviews with individuals. Only in Case Site C did one lecturer seem unwilling to have her classes observed and another asked that the data collected in an observation of her class be withdrawn; both requests were respected. Students were generally willing to be interviewed and have their classes observed in all three sites.

In Case Sites A and B, clinical staff appeared willing to take part but were difficult to access because of their busy schedules. Midwife participants either volunteered to be interviewed or were approached because they worked in areas of high socio-economic deprivation. Educators were selected according to their positions and roles within the organisation and their areas of expertise. Student participants worked alongside the midwives involved in the study and/or attended programmes run by the tutors interviewed. Focus groups were comprised of students about to graduate, as they had comprehensive experience of the programme. Service user interviewees were recruited via midwives who had themselves been interviewed. When considering the data it should be highlighted that they are based on the perspectives of a finite number of participants selected according to the above strategy. In particular, midwives may have referred us to service users with whom they had a good relationship.

Community midwives were asked to nominate women whom they perceived to be disadvantaged, and to give a brief rationale for their nominations. This generated useful data concerning their understanding of 'disadvantage' and how they determined the 'needs' of women deemed disadvantaged in the midwifery context. This had the additional advantage of enabling the researchers to link midwives and service users and, in select cases, to compare their accounts of specific incidents and scenarios.

One inevitable drawback of recruiting women via their midwives' nominations was that the researchers undertaking the fieldwork had knowledge about individuals' circumstances prior to interviewing them. The interviewers often felt uncomfortable about this, especially when midwives related to them as fellow professionals with 'rights' over confidential information. However, as a research team, we were equally interested in the accounts of both the midwives and service users, and these would, necessarily embody differing and even contradictory perspectives, raising interesting and relevant issues for analysis.

Thus we did not seek to establish the 'truth' about a particular service user, viewpoint or incident, but to analyse the various perceptions and interpretations offered and locate those accounts in a wider socio-cultural context. For example, we were interested in how a particular midwife understood disadvantage in her caseload, which service users she identified as disadvantaged and why and how she went about determining and attempting to meet these service users' needs. When it came to interviewing the women identified by midwives as disadvantaged, the researchers were interested in how they defined their needs in the midwifery context. In the analysis of case site data, we were therefore able to show different understandings of what it means to be disadvantaged. Furthermore, this method enabled us to explore how different interpretations of the needs of such service users led to different priorities being set both within and between midwives and service users. These may account for the variation in what actually happens in relation to client care.

### 2.6.4.3 The issue of informed consent

Standard procedures were followed for obtaining informed consent as required by the ethics committees in each case site. Each participant was given an information sheet and consent form that they were asked to sign. In most cases, gaining consent was relatively easy; however, the process of gaining informed consent from service users was not always straightforward. In the first instance, the midwives who nominated them were asked to telephone and/or visit the women to explain the project and give them the information sheets. Only after the midwife informed them that women were willing to be interviewed did the fieldworkers approach them, usually by telephone. Women who were not on the telephone were sent a letter with a reply slip and stamped addressed envelope. When we visited women's homes to carry out the interview, we explained the project and asked them to fill out a consent form. Therefore, the women were given at least two verbal explanations of the project and the information sheet. Despite this, some women clearly expected us to offer a professional service in the field of health or social care, rather than an interview.

This raises important questions about the notion of informed consent when recruiting participants who are unfamiliar with research practices. Despite the best efforts to secure informed consent, there will be times when researchers will feel that some participants are less well-informed and, therefore, less fully 'consenting' than others.

#### 2.6.4.4 Anonymity

In recruiting participants, the team drew particular attention to the issue of confidentiality and anonymity. We made it clear to participants that we would endeavour to maintain anonymity by changing elements of the data that might identify them. Whilst this is standard procedure in such sensitive research, it is not without its drawbacks. In particular, in choosing not to identify individuals by their precise roles, important contextualising data may be lost. For example, programme leaders were not identified as such, despite the fact that their comments about their programmes become more interesting and relevant when read in the context of that role.

### 2.6.5 Content of interviews and observation

Interviews, observations and focus group discussions were carried out in all three case sites.

#### 2.6.5.1 Interviews

The interviews were semi-structured; the following is a summary of each schedule.

The midwives' interviews explored:

- the midwives' education and practice background
- views concerning the meaning of terms such as 'disadvantaged', 'equality of care', 'inequalities in health'
- links between education and practice
- students' educational experiences and assessment processes
- the provision of care to disadvantaged women in their caseload
- constraints on the delivery of equality of care
- personal experience of disadvantage.

The students' interviews explored:

- the students' education and practice background
- views concerning the meaning of terms such as 'disadvantaged', 'equality of care', 'inequalities in health'
- links between education and practice
- students' educational experiences and assessment processes
- the provision of care to disadvantaged women in their practice placements
- constraints on the delivery of equality of care
- personal experience of disadvantage.

The educators' interviews explored:

- the lecturers' education and practice background
- views concerning the meaning of terms such as 'disadvantaged', 'equality of care', 'inequalities in health'
- links between education and practice

- students' educational experiences and assessment processes
- the teaching of provision of care to disadvantaged women
- constraints on the delivery of equality of care
- personal experience of disadvantage.

The interviews with service users explored:

- the woman's social and educational background
- health and pregnancy experiences
- needs during pregnancy
- experiences of midwifery care.

#### 2.6.5.2 Focus groups

Focus groups were carried out with student midwives in each case site. Topics covered were broadly in line with those explored within the individual student interviews.

#### 2.6.5.3 Classroom observations

Classes were selected on the basis of relevance to the research. Some modules or sessions that directly addressed inequalities were selected, however in order to ascertain whether inequalities issues were embedded throughout the curriculum as was often stated to be the case, some random selection was undertaken. The list below gives a broad outline of the topics covered in classes observed across the sites:

- domestic violence
- learning difficulties
- sex therapy
- screening for abnormalities
- team midwifery
- caseload midwifery
- health and social policy
- communication
- role of the midwife
- medicalisation of midwifery services
- feminism
- mental health issues.

### 2.6.6 Interview and observation processes

#### 2.6.6.1 Interviews

Interview schedules for use during the fieldwork were piloted extensively in the researchers' local area, following local ethical clearance. Ten pilot interviews were conducted with midwives, midwifery managers, tutors, students and service users.

A range of techniques were employed to design an accessible interview format for use with service users. In particular, we drew on research with people with learning difficulties and literacy problems (Booth and Booth, 1993) and sought the advice of other academics involved in research in this area. Drawing on participatory research techniques, the use of pictorial representations (de Konig and Martin, 1996) was experimented with in pilot interviews.

Service users were asked to produce drawings of their local area and to depict personal network diagrams as appropriate. For example, working together with the service user to map their neighbourhood, support networks etc. Whilst these proved extremely successful in eliciting a full picture of the service user's lifestyle, time constraints and problems relating to incorporating such data into the specific focus of our analysis meant there was insufficient scope to make full use of this material.

In keeping with research influenced by grounded theory, pilot interview schedules were designed to be as open as possible, and this was followed through in the main study. Despite acknowledging that their personal standpoints would inevitably influence the research, the fieldworkers were keen to minimise the imposition of their perceptions on to interviewees, and avoided using both leading and closed questions. They were also aware that some service users might find it difficult to articulate their views and feelings in the context of a research interview, and were keen not to 'put words in their mouths', a serious methodological concern in this type of research.

However, attempts to keep the interview guide as open as possible were balanced by a concern to maintain a focus on issues relevant to the project. Of major concern was the need to explore interviewees' perceptions in sufficient depth to move beyond people's public accounts of disadvantage and inequality and explore beyond the rhetoric (Sapsford and Abbot, 1998). This was especially relevant in the case of professionals' accounts. Given the organisational and policy contexts within which professionals were working, and their knowledge of the focus of the research, it was unlikely that they would claim anything other than a commitment to addressing inequalities. Furthermore, interviewees in social research generally strive to put forward the best impression of themselves and to rationalise their thoughts, feelings and actions (Fielding, 1993). Thus, the researchers attempted to move beyond the rhetoric by asking interviewees not simply *whether* but also *how* they addressed inequalities. They were asked about specific incidents or scenarios where they felt they had addressed issues of inequality and disadvantage in their teaching or practice and how they now felt about what had occurred. The researchers were also able to use these data to analyse the degree to which interviewees were reflective about their own practice. On the whole, both lecturers and midwives were more likely to reflect on what they saw as shortcomings in the practice of their colleagues than on their own shortcomings.

In many ways, service user interviews proved to be the most frustrating. They were often extremely time-consuming to organise and undertake, partly a result of using midwives as gate-keepers. Another frustration was the paucity of some of the data collected within the context of a one-off interview. In some cases, interviewers found it difficult to elicit responses beyond the 'yes', 'no' and 'maybe'. Many interviewees were clearly not accustomed to being asked for their opinion and some were unclear as to why they were being interviewed at all. Whilst this was frustrating for interviewers, these kind of difficulties are common.

Another problem in social research is that when interviewees feel relatively powerless in society, their expectations will tend to be low and they may, therefore, express satisfaction with the care they received. For example, in relation to quality assurance interviews with social work clients, Dominelli has argued that:

> *'Few people will complain if they feel alternatives are unavailable to them … even direct questions seeking their views prompt a neutral or slightly positive response like "fine". If an evaluation fails to address the relative powerlessness of the "client" being asked to express an opinion, it may produce meaningless responses for evaluation purposes. Clients' failure to voice dissatisfaction or express opinions about services gives no ground for assuming that the situation is satisfactory.'* (Dominelli, 1997: 227)

In the light of such observations, interviewers were careful to encourage the interviewee to express any dissatisfaction they might have felt with the midwifery care they received, as well as to comment on good practice. Interviewers facilitated women to talk at length about issues not directly relevant to the research in order to build up trust, then, as the interview progressed, the women were asked more specifically about their experiences of midwifery care. This theme was returned to time and again, with interviewers asking women what they needed or wanted, what was good or bad about the care they received and what they would have wanted to be different. The fact that many women felt able to express some negative views might be considered testimony to the success of the interview techniques used. Despite the relative success of the interviews in eliciting information, Dominelli's points should be borne in mind when considering the issue of data validity.

### 2.6.6.2 Observations

The purpose of the classroom observations was to examine *how* inequalities issues were addressed. The researcher was able to identify the means by which tutors attempted to make such issues accessible to students and how students, in turn, engaged the issues. When interpreting the data it should be borne in mind that even in situations in which the researcher was not an active participant, her presence may have affected what happened during the observation. Extensive, contemporaneous field notes were taken and then expanded soon after the session or event observed.

Each case site was studied over a three-month period, so classroom observations are not representative of the whole curriculum. However, they do give some indication of different ways of teaching and learning about inequalities in health.

Most observational work was concentrated in the classroom setting. However, some practice observation was undertaken, including visiting specialised provision. More general observation was undertaken with the midwives and other informants interviewed, to provide a context for the extensive interview data and facilitate access to informants within the case sites.

### 2.6.7 Analysis of case site data

All interview data were fully transcribed. Data from the interviews and observations were categorised and coded thematically. Whilst two team members were responsible for coding and categorising the data, all members read the transcripts and commented on the coding categories. The researchers then progressively focused on areas which illustrated key issues relating to the midwifery education and practice in the context of work with disadvantaged clients (Partlett and Hamilton, 1977). Individual responses and observation episodes were compared and contrasted, with each case site being written up as separate chapters (Glaser and Strauss, 1965; Strauss and Corbin, 1990). The final chapter explores pertinent issues raised across the case sites, in the literature review and from the questionnaires in relation to developing midwifery education in the area of care to disadvantaged clients.

Case site analyses were also subjected to a process which drew on the concept, developed by grounded theorists, of participant validation (Glaser and Strauss, 1965). Grounded theory requires:

> *'The development of a systematic understanding which is clearly recognisable and understandable to the members of the setting and which is done as much as possible in their own terms; yet it is more systematic, and necessarily more verbal, than they would generally be capable of expressing.'* (Glaser and Strauss, 1965: 124-125)

The fieldworkers returned to each site after undertaking initial analysis and presented summaries of the preliminary findings. Participants were asked to document their views on the findings, and were also asked to consider the possible recommendations that the research might generate.

Feedback sessions lasted between one and two hours. Sessions at Case Sites A and C were well attended, however there was a poor turnout at Case Site B. Across all three sites participants at feedback sessions were broadly in agreement with the findings. Findings which caused most discussion, were those drawing attention to issues relating to power relationships between participants, for instance between service users and health professionals, students and educators, or health advocates and midwives.

Key individuals within each case site were also asked to read the draft of the site analysis to check for accuracy, anonymity, etc. We received valuable feedback from participants in each site, and where relevant, in the analyses have explicitly documented feedback received.

With data relating to issues of power, the limitations of the pure grounded theory approach to participant validation become particularly apparent. In all cases, where there was disagreement from participants regarding the interpretations we resolved to revisit the original data. If we still considered the interpretation to be representative of what participants said, or what was observed, rather than simply adjusting the data to reflect the perceptions of research participants who gave feedback, we have endeavoured to include within the report a discussion of these differing perceptions.

CHAPTER 3

# DEFINING DISADVANTAGE, CONCEPTUAL ISSUES IN THE HEALTH CARE CONTEXT

### Key Points

- This chapter focuses on the broader health and social care literature that explores the issue of disadvantage.
- Disadvantage has been defined in both 'structural' and 'individual' terms. The researchers argue for an approach that takes both into account in understanding the social experience of disadvantage. Only by combining the two approaches can midwives deliver appropriate care.
- The social work literature is explored because social work focuses on working with individuals and groups who are disadvantaged, and the accompanying literature is therefore comparatively sophisticated in its debates. Both anti-oppressive and anti-discriminatory agendas are popular within social work.
- The difference between anti-oppressive and anti-discriminatory practice is explored. Anti-oppressive practice is about the empowerment of individuals in terms of their rights, not simply their needs. Anti-discriminatory practice requires the practitioner to challenge inequality, prejudice, racism and discrimination.
- There is currently no specific requirement for nurses, midwives or health visitors to address issues of inequalities in health in practice. The *Code of Professional Conduct* (UKCC, 1992) does, however, state that they are responsible for recognising and respecting the uniqueness and dignity of each client, irrespective of their ethnic origin, religion etc.
- *The Midwives' Rules* (UKCC, 1998) provide broad requirements relating to midwifery education, but again do not specifically mention anti-discriminatory agendas.
- Thus while both documents hint at structural issues, the emphasis is on 'appreciation' and 'recognition' of social, cultural and political contexts rather than with challenging the discrimination and the disadvantage that can arise.
- The concepts of 'individualised care', 'woman-centred care' and 'holistic care' are common in midwifery. It is widely agreed that they refer to the meeting the needs of individual women. However, how such needs are defined is less universal. The definition of these concepts, and the manner in which they are operationalised in order to meet the needs of women from disadvantaged groups are crucial to explore.
- The researchers aim to explore the relationship between (i) the ways in which midwives, midwifery educators and midwifery students conceptualise and employ the notion of disadvantage and its related concepts in specific contexts, and (ii) the kind of care clients receive.

## 3.1 Introduction

The focus of this study required us to reflect on the meaning of the term 'disadvantage' and the means by which individuals become defined as 'disadvantaged' in the midwifery context. Therefore, both the midwifery literature and the broader health and social care literature that explores these issues were reviewed.

This chapter begins by situating these literatures within the sociological literature that argues that disadvantage is a contested term with different meanings in different contexts. The review considers how disadvantage has been defined in both structural and individual terms and how the two are understood to interact. Following Giddens (1984), we argue for an approach that takes into account both structure and individual agency in understanding the social experience of disadvantage.

The review examines how different definitions of disadvantage have informed different models of practice in social work and health care. It is useful to examine the social work literature because social work specialises in working with disadvantaged individuals and groups and its literature is, therefore, sophisticated in its debates about such issues. From a comparison of social work and health care literatures, more structurally focused 'anti-oppressive' and 'anti-discriminatory' models of practice are seen to dominate in social work and a more individually-focused 'individualised care' model in midwifery. This comparison between social work and health care literatures draws attention to more and less politically explicit models of practice.

The review concludes by arguing that, in seeking to develop understanding of the ways in which both structural and individual factors are constitutive of disadvantage in the midwifery context, consideration of the roles of health care organisations and practitioners themselves are of central importance. The final section attempts to map the factors influencing approaches taken by midwives when caring for women from a range of groups identified in the midwifery literature as disadvantaged.

## 3.2 Disadvantage: the sociological context

As commentators such as Williams (1983) have made clear, concepts such as disadvantage are always contested, having different meanings and referents in different contexts and at different historical moments. Nevertheless, it encompasses individuals whose identities may be constructed in relation to such concepts as impairment, discrimination, prejudice, poverty, social exclusion, inequality, membership of minority group, of low educational achievement. Each has a particular historical, social and political significance, and although these may be relatively wide-ranging, they are not arbitrary.

In the context of contemporary British midwifery, the wide range of possible applications of the concept of disadvantage is such that it could be argued that almost every pregnant woman could be identified as disadvantaged in some way. However, whilst broader definitions of disadvantage and related concepts are considered, this study concerns itself primarily with spheres of human existence identified, in the midwifery context, as highlighting particular disadvantage. The possible characteristics or experiences that might contribute to people being classified as disadvantaged can be divided into five categories:

1. mental or physical impairment
2. particular characteristics, no longer attributed to mental or physical impairment, which have historically led to individuals experiencing prejudice and discrimination (e.g. ethnicity, gender, etc.)
3. clients who experience prejudice
4. clients who experience discrimination
5. clients living in material poverty.

Categories 1 and 2 could be said to be primarily related to the person (internal locus), whilst Categories 3 and 4 are concerned with the manner in which other individuals and institutions relate to those in Categories 1 and 2. Category 5 could be consequential to any of the other four. However, all five categories may be applicable in relation to health care provision for certain individuals.

The present study concentrates on individuals who represent a constellation of the above categories. Our study suggests that such individuals represent the greatest challenge to midwifery care, not least because of the problems of defining and recognising disadvantage in such a way that appropriate care can be offered. Most commentators acknowledge that disadvantage is socially constructed and that its experience is always affected by wider social, economic and political forces (Nettledon, 1995). However, the precise interplay between social constructions and material realities of disadvantage continues to be widely debated (e.g. Ussher, 1997).

33

Ahmad and Husband (1993) highlight the need for an analysis of the interaction between ethnicity and other variables. They stress that an ethnic definition of need necessarily obscures the social and structural basis of the need, and helps to perpetuate the marginalisation of the minority client. This argument holds true for other disadvantaged users of the health service.

In the context of midwifery, it is possible to see disadvantage as constructed, in part, in the practice of delivering care. In the case of any individual client, there could be said to be a working definition of her particular disadvantage, itself the outcome of negotiations between different stakeholders, including the client, her family, and the professionals involved in her care. In this study we do not offer a fixed definition of disadvantage, but are concerned to identify the different definitions in play, the conflicts they generate and the resolutions found in specific contexts.

Debates about what constitutes disadvantage are linked to wider debates about what constitutes reality and whether it is even justifiable to talk about a 'real world' which exists outside an individual's experience. Debates have focused on the relative importance of *structural* and *individual* factors in constituting social experience. Most commentators insist on the interplay between structural and individual factors. Social, economic and political contexts play a major role in structuring individuals' lives. However, those individuals play a role in defining and shaping both their own experiences and, ultimately, the structures that seek to define them (Giddens, 1984; Popay et al., 1998).

This debate has relevance for midwives, who must remain aware of both structural and individual aspects of disadvantage. They may draw on macro studies employing epidemiological and statistical data to enhance their awareness of possible structural inequalities (economic, social and/or cultural) faced by, for example, physically disabled women. However, they may need to draw on microsociological research to enable them to remain open to the possibility that individual disabled women may experience their disabilities in vastly different ways. Only by drawing on both approaches can midwives deliver appropriate care.

This study aims to incorporate clients' perspectives as central to its evaluation of midwifery education. However, it does so within a framework that understands disadvantage and the experience of disadvantage as being constituted within a set of relationships involving:

- the client
- the health care institutions
- the health professionals.

With this in mind, debates concerning the nature of anti-oppressive practice (AOP) and ADP become extremely relevant. These recognise not only the dynamic nature of the construction of a disadvantaged identity in relation to debates about structure and individual agency, but also the relevance of debates about the role and approach of health and social care professionals. Such debates also acknowledge the importance of the concept of *power* when analysing the relationships between health professionals and clients.

## 3.3 Disadvantage in health and social care: competing models

This section examines how different understandings and definitions of disadvantage have informed different models of practice in health and social care.

### 3.3.1 Anti-oppressive and anti-discriminatory models of practice

Both anti-oppressive and anti-discriminatory agendas are popular in social work. AOP is associated with the practice of challenging structural inequalities, and has been described as:

> *'... a form of social work practice which addresses social divisions and structural inequalities in the work that is done with people whether they be users (clients) or workers ... AOP aims to provide more appropriate and sensitive services by responding to people's need regardless of their social status. AOP embodies a person-centred philosophy; an egalitarian value system concerned with reducing the deleterious effects of structural inequalities upon people's lives; a methodology focusing on both process and outcome; and a way of structuring relationships between individuals that aims to empower users by reducing the negative effects of social hierarchies on their interaction and the work they do together.'* (Dominelli, 1996: 171)

Similarly, Preston-Shoot (1995) understands AOP as representing a challenge to structural inequalities. It is, he argues, a practice which:

> *'... seeks change in underlying relationships and assumptions upon which relationships, including service provision, are built. It seeks a fundamental realignment of power structures, commencing with an acknowledgement of structural inequalities, exploitative legal, social and economic relationships, and their impact on individuals and groups. It identifies, therefore, with a radical value base which emphasises user control rather than participation in welfare agencies' agendas, equality rather than equal opportunity, rights not needs, and citizenship more than respect for persons.'* (Preston-Shoot, 1995: 16)

Following these definitions, AOP can be understood as presenting a radical challenge to existing power structures. It focuses less on equal opportunities and access and more on equality of outcome. It is about the empowerment of individuals in terms of their rights, not simply their needs, and prefers to focus on the development of active citizenship amongst clients rather than simply demanding that all clients are respected for who they are. Thus, there is clear recognition that individuals must be empowered to contribute to changing the structures that disadvantage them.

The anti-discriminatory model of practice is often defined in ways that make it indistinguishable from the anti-oppressive model. Thus, for example, the Central Council for Education and Training in Social Work (CCETSW) has adopted an explicitly 'anti-discriminatory' agenda that has much in common with an anti-oppressive one. In describing the CCETSW approach, Preston-Shoot states that:

> *'CCETSW continues to affirm that issues of discrimination are integral to social work training, and that counteracting inequality and discrimination is central to any definition of good practice. Definitions of competence will include the practice requirements of assisting people to improve the quality of their lives, by challenging inequality and building on strengths and diversity. The evidence indicators for this requirement, rather than being just pointers to types of activities that would demonstrate this requirement in practice, must be met specifically. They include challenging inequality, prejudice, racism and discrimination; respecting uniqueness and valuing diversity; and supporting people's rights of choice, privacy and protection.'*
> (Preston-Shoot, 1995, quoting from CCETSW, 1994)

Here again there is an emphasis on challenging inequality with a responsibility on the social work profession to take an active role. However, AOP and ADP have their critics. Even within the CCETSW, although the broad requirements remain the same, the precise relevance and practicality of such practices have been hotly debated since 1994. Preston-Shoot (1995), in particular, has argued that AOP is more radical than ADP in that it challenges both structural and individual aspects of inequality and disadvantage, but others argue that even anti-oppressive agendas are unlikely to bring about significant reductions in inequality. Indeed, Williams (1999) has referred to AOP as a 'politically sterile model' which:

> *'... adopts many guises under the cloak of equal opportunities and anti-discriminatory practice, focusing on competency in managing diversity. Its approach proclaims difference as essential in distinguishing need and prescribes responses to that need as a technical activity stripped of critical or radical ambition for change. It is essentially individualistic, populist and pragmatic, and effectively operates to dissipate the politicisation of need by holding that everyone's needs are unique and special.'* (Williams, 1999: 226)

Williams points to the immense difficulties that anti-oppressive theories pose to social work practice:

> *'Anti-oppressive theory, by definition, suggests a radical model for practice within an institutional and bureaucratic structure that can at best accommodate only marginal and incremental changes more akin to liberal approaches.'* (Williams, 1999: 224)

She goes on to ask:

> *'How will the strategies differ for different forms of oppression given that some have legislative backing and others do not?'* (Williams, 1999: 224)

In health care, too, there is debate about the relative importance of structural and individual aspects of disadvantage and inequality. For example, the field known as 'transcultural nursing' has concerned itself with the issue of nursing in specific cultural contexts (e.g. Leininger, 1991). Transcultural nursing espouses the need for 'culturally-sensitive' care, with health care interactions being central. However, recent commentaries on transcultural nursing have criticised this approach for failing to address structural factors within which those interactions take place:

> *'Although the transcultural view approaches other cultures with respect, it does not recognise that no health care interaction is ever simply objective. Rather the nurse always operates from her/his own cultural mindset which influences how she/he relates to those she/he cares for. Also every particular health care interaction is to some extent influenced by the cultural context in which it occurs ... Focusing on individual interactions, as in the transcultural view, is inadequate without a recognition of the influential social structures within which all such interactions take place.'*
> (Polaschek, 1998: 453)

As part of a critique of transcultural nursing, the concept of 'cultural safety' has been generated in work in New Zealand and Australia (Polaschek, 1998) on nursing people of different ethnicities to that of the nurse:

> *'"Safety" in cultural safety, derived from the idea of safety in nursing, suggests a standard that must be met or one's activity is unsafe. However, it is recognised that it is not analogous to other forms of physical safety but is more like an adequate ethical standard.'* (Polaschek, 1998: 452)

Thus the notion of cultural safety, like the concepts of AOP and ADP, emphasise the role and attitude of practitioners in constituting disadvantage, rather than focusing solely on the client's identity and experience (see also Sayce, 1998). For Wood and Schwass (1993), nursing practice that is culturally *unsafe* includes: *'... any actions which diminish, demean or disempower the cultural identity and well-being of an individual'* (cited by Polaschek, 1998: 453).

This can be contrasted with culturally-*safe* nursing practice which involves actions which recognise, respect and nurture the individuals' cultural identity and safely meet their needs, expectations and rights (Wood and Schwass, 1993, cited by Polaschek, 1998).

Despite the popularity of cultural safety as a concept in New Zealand, and the fact that it has been adopted at policy level (Ramsden, 1995), it has also been severely criticised (Polaschek, 1998). One area of debate concerns the extent to which it can be applied in other contexts. Some commentators advocate widening the application of the concept to other forms of oppression such as sexism, ageism and homophobia (Ramsden, 1995), but others suggest that:

> '*... stretching the word culture to encompass all forms of collective identity diminishes the power of the concept.*' (Polaschek, 1998: 455)

Polaschek argues that the characteristics of different identities need to be addressed in their own terms. However, as is argued here and in Chapter 4, there are commonalities (and differences) of experience amongst disadvantaged groups and, in terms of practice, it is important that these are understood. However, midwives tend to understand 'culture' and 'the cultural' to include only issues of ethnicity and race. Thus, extending a concept such as cultural safety to other forms of oppression might appear confusing. For the purposes of the study, the idea an 'inequalities imagination' has been developed, which involves the development of a set of generic attitudes, skills and behaviours that enable midwives to deliver appropriate care to all disadvantaged clients. This idea, and its relationship to Wright Mills' (1959) notion of the 'sociological imagination' is explored in-depth in Chapter 9.

Like transcultural nursing, cultural safety has been criticised for focusing too much on micro-interactions between clients and practitioners, at the expense of wider structural issues. Furthermore, its vague nature has been called into question (e.g. Polaschek, 1998), as has its emphasis on nurses' *attitudes* rather than *behaviours*. Despite these criticisms, the concept clearly has relevance to this study, precisely because of its emphasis on the role of practitioners in either reinforcing or challenging disadvantage.

Campinha-Bacote's (1999) work on cultural competence is also relevant. She suggests that the process of cultural competence in the delivery of health care is of striving towards rather than assuming achievement. The first of the five aspects of her model, cultural awareness, requires appreciation of and sensitivity to values and beliefs of a client's culture but involves the examination of the possible ethnocentricity of one's own values and beliefs. The fifth aspect, cultural desire, is *'the motivation of the health care professional to "want" to engage in the process of cultural competence'*. Campinha-Bacote explains that although health professionals might possess cultural awareness, knowledge and skill, without an honest commitment to care, these become meaningless. This sentiment transfers across all types of disadvantaged service users.

Thus a range of work has explored care-giving in cultural context. These issues, regarding the giving and receipt of culturally competent care, are discussed in more depth in the case site analyses and also in Chapter 9. Furthermore, in Chapter 9 we draw explicitly on Campinha-Bacote's (1999) work as a starting point for the development of our 'inequalities imagination' model.

### 3.3.2 Approaching disadvantage in midwifery: the individualised care model

Midwives face a number of problems when working with disadvantaged clients. They may lack knowledge of particular ethnic or cultural groups and often have to confront their own and others' prejudices against different cultures. However, these problems are compounded by conflicts about what constitutes disadvantage, especially where midwives work as part of a multiprofessional team, where members work with different understandings and definitions.

At present, there is no specific *requirement* for nurses, midwives and health visitors to address issues of health inequalities in their practice. However, a requirement under Point 9 of the *Code of Professional Conduct for Nurses, Midwives and Health Visitors* (UKCC, 1992), states these professionals' responsibilities in more individual terms:

> *'As a registered nurse, midwife or health visitor you are personally accountable for your practice and, in the exercise of your professional accountability, must … recognise and respect the uniqueness and dignity of each patient and client, and respond to their need for care, irrespective of their ethnic origin, religious beliefs, personal attributes, the nature of their health problems or any other factor.'* (UKCC, 1992)

Thus, the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) falls short of referring to issues of inequalities and/or ADP. Instead, practitioners are required to treat patients with respect, irrespective of their ethnic origin etc., suggesting that these differences are unimportant in shaping their need for care. This liberal approach to inequality, reflected in midwifery's individualised care approach, is often ambiguous about difference and equality issues. At best, cultural and other differences are recognised and respected. Rarely are they understood in relation to disadvantage in a more overtly structural and political sense as in social work.

In relation to midwifery education again, anti-discriminatory agendas are not outlined specifically. Rule 33 of *The Midwives' Rules* (UKCC, 1998) states:

> *'(3) Such programmes of education shall:*
>
> *(c) Enable the student to accept responsibility for her personal professional development and to apply her knowledge and skill in meeting the needs of individuals and of groups throughout the ante-natal, intra-natal and post-natal periods and shall include enabling the student to achieve the following outcomes:*
>
> *(i) the appreciation of the influence of social, political and cultural factors in relation to health care and advising on the promotion of health*
>
> *(ii) the recognition of common factors which contribute to, and those which adversely affect the physical, emotional and social well-being of the mother and the baby, and the taking of appropriate action*
>
> *(iii) the ability to assess, plan, implement and evaluate care within the sphere of practice of a midwife to meet the physical, emotional, social, spiritual and educational needs of the mother and baby and the family*
>
> *(iv) the ability to take action on her own responsibility, including the initiation of the action of other disciplines, and to seek assistance when required*
>
> *(v) the ability to interpret and undertake care prescribed by a registered medical practitioner*
>
> *(vi) the use of appropriate and effective communication skills with mothers and their families, with colleagues and with those in other disciplines.*
>
> *(vii) the use of relevant literature and research to inform the practice of midwifery*
>
> *(viii) the ability to function effectively in a multi-professional team with an understanding of the role of all members of the team*
>
> *(ix) an understanding of the requirements of legislation relevant to the practice of midwifery*

> (x) *an understanding of the ethical issues relating to midwifery practice and the responsibilities which these impose on the midwife's professional practice*
>
> (xi) *the assignment of the midwife of appropriate duties to others and the supervision and the monitoring of such assigned duties.'* (UKCC, 1998: Rule 33)

Thus, even where structural issues are hinted at, the emphasis is on the appreciation and recognition of social, cultural and political contexts rather than with challenging the discrimination and disadvantage that arise in these contexts. In the case site data, many examples of this approach to working with disadvantaged clients were found.

The Board's statements relating to equality issues, which apply to both midwifery and nursing, are more explicit. In 1993 the Board published the following statement:

> *'Institutions seeking approval to conduct programmes would be required to demonstrate a commitment to anti-discriminatory and equal opportunities policies.'* (quoted in Neile, 1996: 17)

The Board's regulations and guidelines, under a section entitled equal opportunities and anti-racism state:

> 1. *'Persons and groups, within the Board's authority, are not to be discriminated against or devalued on the basis of race, colour, gender, age, marital status, sexual orientation, socio-economic background, disability or religious belief.*
> 2. *The Board will address known problems arising from a lack of equal opportunities or from racist activities, for example, overt or covert disadvantages in personnel practices, provision of service or organisation and service methods.*
> 3. *The Board supports flexible curriculum planning at local level which increases opportunities for both pre- and post-registration courses to prepare staff to work in a multi-cultural and multi-racial society. This includes the promotion of equality of opportunity and good relations between people of different cultures and racial groups.*
> 4. *The Board continues to encourage the use of teaching methods in its courses which relate beneficially to ethnic minority citizens. The recognition of a multi-cultural society is incorporated in holistic nursing practice.*
> 5. *The Board continues to assist in the development of education and training resources which promote a valued perception of racial and cultural factors and avoid 'stereotyping'.*
> 6. *The Board continues to welcome the receipt of information which may lead to continued improvement in the areas of equal opportunities and anti-racism.'* (ENB, 1993)

However, even these requirements fall short of developing specific mandates. Given that there are, at best, only implied requirements of midwives to practise in an anti-discriminatory fashion, it is perhaps unsurprising that there is little mention in the literature of AOP or ADP. One might expect organisations such as the Association of Radical Midwives (ARM), to take a lead in this area. Indeed, their vision is that:

> *'... midwifery education, through its content and processes, will be individually and collectively liberating in terms of gender, class, race, sexuality and creed.'* (ARM, 1999: 4)

However, the ARM's most recently published vision of midwifery education does not explicitly and systematically explore the consequences for midwifery education of implementing its philosophy of developing midwives who:

> *'... are able to be with women in any society acknowledging that people continue to experience inequalities, deprivations and injustices as well as a growing number of professional, family and environmental stresses.'*
> (ARM, 1999: 4)

Furthermore, in its discussion of teaching methods and content, inequalities issues are barely implied, and are certainly not systematically addressed. The pamphlet outlining the ARM's vision for midwifery education is not a curriculum document, and should perhaps not be expected to be detailed. Nevertheless, this lack of a clear follow-through from philosophy to teaching and learning methods, content and assessment is a general feature of documents outlining midwifery education, in relation to inequalities.

One commentator who addresses directly notions of AOP is Neile in her work on anti-racist practice (Neile, 1996; 1997a; 1997b). A further exception is a short section in a book exploring culture, religion and childbearing in a multi-racial society (Schott and Henley, 1996), a comprehensive textbook used widely by midwifery students and lecturers. These works are discussed in more detail in Chapter 4.

Most midwives are educated in the notion of individualised care and it is important to reflect on the relationship of this concept and its practice to other concepts and practices that seek to define and address disadvantage and inequalities. Individualised care is about meeting women's individual needs, but how are those needs defined? The concept of need in midwifery is complex and not one about which all midwives share a view (Hart, 1997). Some may take individualised care to mean 'according to the wishes of that particular woman'. Others will make their own professional judgements about appropriate care on the basis of their perception of the woman's needs, which may be informed by structural and/or individual definitions of disadvantage. Smith (1980) argues that professionals define needs and then present them as if they were objective, despite the fact that such definitions may not concur with those of their clients. Similar points can be made in relation to the concepts of 'holistic' and 'woman-centred' care, which are often used synonymously with individualised care in midwifery. It is important to understand how these concepts are defined and operationalised to meet the needs of women from disadvantaged groups. In particular, it is crucial to identify those stakeholders whose definitions dominate the policy and practice of midwifery.

In the analysis of case site data, definitions of disadvantage are shown to vary according to the priorities in the particular site. Thus, in Case Sites A and B, 'young/teenage mothers' is a priority issue involving the establishment of specialist services, and participants, aware of such initiatives, readily name this group when discussing disadvantage. In Case Site C, such priorities were the preserve of social services, and participants in this site were less likely to mention this group in relation to disadvantage.

Thus, the study seeks to identify the understandings and practices of different stakeholders in relation to what it means to 'meet the needs of women from disadvantaged groups' and to locate these understandings and practices within the context of the particular case site. Specific attention is paid to resource issues and the ways in which these impact upon priority setting in relation to midwifery services for disadvantaged clients. For, as the Department of Health has argued, need is a relative concept:

> *'... the definition of which will change over time in accordance with changes in national legislation ... local policy, the availability of resources, the pattern of local demand.'* (DoH, 1991: 12)

This study aims to take these contextual factors into account through its incorporation of detailed studies of three sites in the UK where resources and demands differ enormously.

## 3.4 Framing midwives' perceptions of disadvantage

This exploration of concepts and meanings is not undertaken simply as an academic exercise. The aim is to explore the notion that the ways midwives and midwifery educators and students *conceptualise* and *employ* the notion of disadvantage and its related concepts in specific contexts may affect the kind of care midwives give, and the manner in which they give it. An issue explored in the case sites is the degree to which the particular educational context in which students develop their professional identity affects the conceptualisation and employment of concepts. This research establishes that not all midwives feel their practice should be tied more closely to wider social and political policy concerning inequalities in health and the need for broader, community-level working. In contrast, Tyler asserts that:

> *'Midwives must become more socially and politically aware, to work to make quality maternity care a reality for every woman.'* (Tyler, 1994: 554)

Crafter takes a less forthright approach, suggesting that:

> *'Awareness and a basic understanding of inequalities in health and health care are necessary to all those involved in providing a health service because the distribution of health care still appears to be dependent to a great extent on socio-occupational status rather than need. The inequalities – present from birth right through until death, from the planning of health care through to its provision and evaluation – are one of the great challenges for health planners and workers since the discrepancies between classes have been known.'* (Crafter, 1997: 34)

The different frames of reference within which midwives work need not, of course, be mutually exclusive, and empirical evidence may be established in relation to their co-existence. Our work with midwives, student midwives, and midwifery educators, and our review of the literature, suggests that a wide range of sources influence midwives' actions in relation to individual disadvantaged clients in particular contexts. However, these sources do not always facilitate a critical appreciation of the social and political issues to which Tyler (1994) refers. The analysis of study site data attempts to establish what motivates individual students and midwives to take particular approaches to their care and how far, in the case of students, such motivations have been shaped through education.

The degree to which *educational* provision is responsible for midwives working within any particular frame of reference regarding inequalities and disadvantage, is difficult to tease out. This will be particularly difficult in relation to midwives who qualified some time ago, and may not be undertaking post-registration study directly related to issues of inequalities. When analysing focus group and interview data pertaining to student midwives this should be less difficult because their educational experience, as a recent, or ongoing, phenomenon, may prove extremely important in explaining their thoughts and actions.

Just as midwives' conceptual horizons concerning disadvantage are inextricably bound up with the care they give to individual clients, so clients' perceptions of their own disadvantage affects the ways in which they manage their relationships with midwives and other professionals. For example, some may not perceive themselves to be disadvantaged, and would possibly not welcome the kind of care a midwife may explicitly or implicitly offer. Some may perceive the midwife to be reinforcing their disadvantaged status by prejudicial behaviour or by aligning with other health professionals. This is sometimes the case when child protection issues are involved, and is discussed in relation to the surveillance issue in the case site analyses. Equally, there may be times when clients who would normally reject the label 'disadvantaged', actually seek to use it to their advantage. They may 'strategically essentialise' their experience and identity to take advantage of specialist groups, benefits and services. For example, a woman with a diagnosed mental illness may generally prefer to deny she has that illness, whilst being prepared, at times, to construct herself as mentally ill (for example, on a benefit form) to achieve specific outcomes. Clients experience and construct their own disadvantage in complex, and often many contradictory ways according to the context.

## 3.5 Conclusion

These wider debates on the nature of disadvantage, the identity politics that relate to it, and the debates about structural inequalities, make it difficult for researchers to establish how to frame their data collection and analysis. In this study, the research is framed in terms of an attempt to identify the types of understandings, ideas and influences that midwives draw upon when seeking to meet the needs of disadvantaged clients to ascertain how such understandings, ideas and influences affect the care given.

A number of authors in midwifery now support the argument for a focus on conceptual issues, rather than solely on immediate practicalities. In so doing, they draw on the debates and arguments reviewed in this chapter.

According to Wilton (1996), it is time that midwives reflected more broadly on the care they give:

> *'Despite the increasing professionalism of midwifery, there remain areas which for far too long have been dogged with ignorance and bad practice.'*
> (Wilton, 1996: 126)

Wilton (1996) draws on the work of Siddiqui (1994), albeit somewhat out of context, asserting that this is *'partly due to a general resistance to problematising midwifery knowledge'* (Wilton, 1996: 126). Siddiqui comments that:

> *'The midwifery curriculum has, for years, paid lip-service to philosophical enquiry, assuming that concepts such as autonomy, advocacy, and respect for persons were implicit in the programme.'* (Siddiqui, 1994: 421)

Furthermore, Kirkham and Perkins (1997) warn:

> *'In the UK in recent years, and particularly since the publication of the Winterton report (House of Commons, 1992) and Changing Childbirth (DoH, 1993), there has been considerable impetus to improve midwifery care. Many projects have sought to improve the client's childbearing experience and often also to improve the midwife's skill and job satisfaction. This impetus is cheering, but there is a danger of trying to implement ideas that are still slogans rather than fully analysed concepts. Without analysis there is insufficient conceptual basis on which to build strategic plans and little sense of strategic priorities in the face of cuts for funding. Within this analysis there is a particular need to examine the ironies, dilemmas and sometimes contradictions within our endeavours.'*
> (Kirkham and Perkins, 1997: vii)

Whilst the results of the curriculum analysis largely support this critique of midwifery curricula, interview and observation data analyses suggest that many individual midwives and lecturers do incorporate such critical thinking into their education and practice. However, unless they are in key positions, enabling them to control resources and effect change at institutional level, such critiques can have only minimal impact. This point is illustrated in the case site analyses, especially in relation to Case Site C.

Chapter 4 considers the relevant policy contexts relating to issues of disadvantage and inequalities in health, and discusses some specific texts concerned with issues of disadvantage that in the midwifery context.

## Key Points

- This chapter considers the contemporary health policy context within which debates about midwifery and disadvantaged clients needs to be understood, and the ways in which clients defined as disadvantaged have been addressed within the midwifery literature.
- *Changing Childbirth* (DoH, 1993) failed to include an indicator of success specifically related to the needs of disadvantaged women. Indeed, it has been criticised for concentrating on the views of affluent, articulate service users, who are thought to have little insight into the needs of those living with, for example, a disability, in poverty or on the margins of society.
- Current Government policy for improving the health of the nation is focused around the need to concentrate on areas of social deprivation. Its other main thrust is to encourage closer collaboration between the NHS and local government-based services such as social services. Implied within these policies is an expanded role for health professionals, including midwives, in respect of health education and promotion.
- Health Action Zones and Sure Start are examples of the Government's drive to tackle health inequalities, prevent illness, minimise social exclusion, reduce the number of teenage pregnancies and improve the social development of children.
- *Making a Difference* (DoH, 1999) suggests that health promotion should become a greater part of the midwife's role and that midwives should target vulnerable groups who would not traditionally use the health promotion service.
- The majority of the midwifery literature relating to disadvantaged clients concentrates on individual accounts, or interventions with specific groups, in line with the concept of individualised care; very little addresses the broader socio-political issues. The researchers speculate that midwives feel hindered by a professional identity that discourages active political engagement.
- No single approach to meeting the needs of disadvantaged women dominates the midwifery literature. The notion of women with special needs is widespread. However, the notion of individualised care, which seeks to avoid the stereotyping that can occur when people are grouped into categories, is also prevalent.
- Whilst most commentators continue to accord midwives a central role in providing care for disadvantaged women, the women themselves may see midwives as less important than other professionals, such as those providing housing or financial assistance.
- Midwives have been described as providers of social support and advocates for disadvantaged women, and their role in the provision of parent education has also received attention. In particular, there are concerns about the correct balance between providing mainstream education classes and specialised classes for disadvantaged women.
- The midwifery literature covers a large range of practical issues relevant to midwives caring for women who need additional support or who are disadvantaged in some way. For example, women from ethnic minorities, women living in poverty, young mothers, and women with disabilities.
- The consensus from most of this literature is that a number of skills are required by midwives who work with disadvantaged clients, including: an understanding of the woman's social and cultural background, and the ability to advocate for the client in relation to medical and other colleagues, overcome personal and societal prejudices, and practise in a reflexive manner.

- **The literature suggests that the knowledge, skills and attitudes which midwives require in order to care for disadvantaged women are acquired during their lifelong career rather than in their pre-registration period alone. This is endorsed in *Fitness for Practice* (UKCC, 1999).**

## 4.1 Introduction

In Chapter 3 it was argued that whilst 'disadvantage' and 'disadvantaged identities' are historically and socially contingent, some disadvantaged identities are less open to conjecture than others. Indeed, the current Government has highlighted poverty, social exclusion and social deprivation as areas of particular concern. This chapter considers the contemporary health policy context within which debates about midwifery and disadvantaged clients must be understood, and considers some of the ways in which clients defined as disadvantaged have been addressed within the midwifery literature.

## 4.2 The broad health policy context

The notion of 'inequalities in health' is now commonplace in both health literature and policy. The concept of inequalities in health acknowledges that there are clear differences in the health outcomes of people of different social classes that can be linked to the unequal distribution of health care resources. The controversial report, *Inequalities in Health*, also known as the Black Report (DHSS, 1980), was influential in framing debates around inequalities in health. The more recent Government-commissioned *Independent Inquiry into Inequalities in Health* (DoH, 1998c) has taken many issues raised in the Black Report much further. A key recommendation that is of considerable importance to midwifery states:

> *'We recommend a high priority is given to policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children.'* (DoH, 1998c: 1)

It is too early to tell how the Government will respond to this recommendation, but the consultation document *Supporting Families* (Home Office, 1998) considers the needs of expectant women and those with young children to be of utmost importance. Furthermore, Sure Start, a Government-initiated multidisciplinary service designed to ameliorate health status in under-five-year-olds, is targeted at areas of high socio-economic deprivation.

The important role of the NHS in combating inequalities in health is highlighted in many contexts. For example, *Tackling Inequalities in Health: An Agenda for Action* suggests that the NHS has three key obligations:

> *'To ensure that resources are distributed between local areas in proportion to their relative needs;*
>
> *To respond appropriately to the health care needs of different social groups;*
>
> *To take the lead in encouraging a wider and more strategic approach to developing healthy public policies.'* (Benzeval et al., 1995: 95)

Such obligations clearly have relevance for midwifery although, as the case site analyses indicate, awareness of this relevance is variable across the case sites with only Case Site C showing strong evidence of attempts to implement changes in line with such policy.

The Government has also placed emphasis on tackling the effects of poverty in documents such as *Our Healthier Nation* (DoH, 1998b). However, some have criticised this document for omitting specific targets relevant to midwifery, in particular one in relation to the incidences of low birth-weight babies.

In this context, Howarth et al.'s (1998) indicators, developed to monitor trends in health and social exclusion, include a number that have particular relevance to midwifery and could be used to monitor Government performance in this area:

> *'The incidences of low-birth weight babies that are both concentrated in areas of high socio-economic deprivation and are worsening.*
>
> *The increase in the numbers of conceptions in girls under 16.*
>
> *The increasing incidence of depression.*
>
> *The increasing percentage of the population that is becoming long-term dependent on benefits.*
>
> *The increasing proportion of households who have been without work for two years or more.'* (Howarth et al., 1998)

Government policy for improving health has been focused around the need to concentrate on areas of social deprivation and to improve the health of people in those areas by encouraging closer collaboration between the NHS and local Government-based services such as the social services. One leading expert on health policy has summed up the new agenda in the following way:

> *'The new health policy agenda may be characterised by its emphasis on partnership and on a whole systems approach to tackling health problems, in particular the widening health gap between social groups. Each of the Government's initiatives in health care is designed to reduce health inequalities. In significant ways the emerging health policy agenda is coming closer to social services, and local Government more generally, than ever before in the history of the NHS. The stress on partnership and alliance-building, together with a firmer emphasis on health as distinct from health care, is bringing the NHS into a new complementary relationship with local government.'* (Hunter, 1998: 2)

Implied in this policy is an expanding role for health professionals to include more health promotion and education. However, for such initiatives to succeed, health professionals need to be released from other tasks. The shortage of midwives means that trusts are operating without a full workforce. How are managers to release midwives to undertake tasks that are not concerned with the safe delivery of babies? The split between community and acute trusts, and the fact that many midwifery departments are located within acute trusts, further detracts from the community component of midwifery, particularly when, as in the case sites, a hospital-, rather than community midwifery-led maternity service is in place. The case site analyses in Chapters 7, 8 and 9 throw further light on these issues.

## 4.3 The midwifery policy context

There are important policy contexts in relation to the needs of disadvantaged clients, which relate specifically to maternity care. Central to some concerns about the provision of care to disadvantaged women are discussions about the Conservative Government's policy directives in *Changing Childbirth* (DoH, 1993). Some commentators argue that the report fails to address the needs of disadvantaged women. Both the Winterton Report (House of Commons, 1992) and *Changing Childbirth* (DoH, 1993) have been criticised for concentrating on the views of affluent, articulate and 'health care-savvy' service users, who are thought to have little insight into the needs of those living, for example, with a disability, in poverty or on the margins of society (Cardale, 1992; Hart, 1997).

Irrespective of the source of evidence for the changes in policy recommended, it could be argued that the underlying goal of *Changing Childbirth*, to improve service provision overall, would, by default, benefit disadvantaged women, particularly within a philosophy of

45

woman-centred or individualised care. Indeed, the report included several objectives aimed at providing services that represented and met the needs of the local population in terms of its health, ethnic, cultural and social mix. There was particular emphasis on improving accessibility for disabled women and those least likely to seek care and use it to full advantage. Examples of good practice were included and at least one maternity unit has responded by targeting the needs of certain categories of disadvantaged women (e.g. Priestley, 1997). Despite these responses, *Changing Childbirth* clearly missed an opportunity to include an indicator of improvements in maternity services that directly and specifically related to the needs of disadvantaged women.

In the wake of *Changing Childbirth*, there is growing evidence that one of its key 'success indicators', that at least 75% of women should know the person who cares for them during their delivery, is problematic when examined from the point-of-view of disadvantaged clients (Hart, 1997; Lee, 1997). Whilst changes to maternity services have largely been driven by this indicator more than any other, evidence is emerging that continuity of carer into the intrapartum period may hold little significance for many disadvantaged women whose priorities lie elsewhere. For example, some literature supports the view that social support and multi-agency collaboration in the ante-natal and post-natal period are thought to be of greater importance to, and offer greater benefits to, disadvantaged women than does continuity of carer into the intrapartum period (Oakley et al., 1990; Cardale, 1992).

Hall et al. (1980) suggested that fewer ante-natal contacts would allow more time for social support during the remaining contacts. More recently, the Audit Commission argued for fewer routine ante-natal contacts:

> *'Providing more care than is needed means poor use of resources which could be better targeted at improving information and support for women, particularly those with more complex needs.'*
>
> (Audit Commission, 1997: 27)

Hodnett and Roberts (1997) report that home-based support for disadvantaged women who have recently given birth may reduce the risk of accidental or deliberate harm to their child.

Clearly there are difficult choices when resources are limited. *Making a Difference* (DoH, 1999a) gives midwives a central role in health promotion in relation to disadvantaged women. This document argues that care should be targeted to those that need it most and that this will, inevitably result in others having less choice. However, there is no mention of increased financial resources with which to develop services.

*Making a Difference* (DoH, 1999a) explains the Government's strategic intentions for nursing, midwifery and health visiting. The Government regards these professions as having a key role within plans to modernise the NHS and to improve the public's health. One of the main thrusts of *Making a Difference* is that nurses, midwives and health visitors should reach out to work within the wider community, and across organisational boundaries in order to provide seamless care. Health Action Zones and Sure Start are presented as examples of the drive to tackle health inequalities, prevent illness, minimise social exclusion, reduce the number of teenage pregnancies and improve children's social development. Those initiatives present particular challenges for nurses, midwives and health visitors. Some trusts involved with 'trailblazing' Sure Start projects have appointed midwives specifically for this work.

Thus, *Making a Difference* (DoH, 1999a) suggests that the role of the midwife increasingly includes tackling inequalities and social exclusion. One in three women who experience domestic violence report that this started during pregnancy. Many midwifery services are responding by training midwives in domestic violence issues, and putting in the appropriate support mechanisms.

The document urges midwives to work with school nurses and health visitors in order to help young people become informed about healthy lifestyle choices. The Government sees midwives as being well placed to contribute on issues such as contraception, sexual health and responsibilities associated with pregnancy and childbirth. Furthermore, *Making a Difference* (DoH, 1999a) suggests that health promotion should become a greater part of the midwife's role, and midwives should target 'vulnerable groups' who would not traditionally use the service. Post-natal continuity of care is important, particularly for the young or vulnerable, and midwives should strive to achieve this particularly for those groups.

This vision of an enhanced role for midwives in addressing inequalities is shared by the Royal College of Midwives (RCM). In its document *Vision 2000* (RCM, 2000a) it is clear that the 'unique' role of the midwife should have a strong public health emphasis:

> *'She [the midwife] will work as a public health practitioner, promoting community wellbeing and reducing inequalities in health through health promotion, health profiling, tailored service provision, and working in creative partnerships across professional and sectoral divides.'* (RCM, 2000a: 14)

Acknowledging the changing role of the midwife, *Vision 2000* goes on to say *'midwives themselves will need to re-interpret their role in order to meet the changing needs of mothers and infants'* (RCM, 2000a: 14). In keeping with the recent political climate the role of the midwife is changing. As the case site data show, practitioners are often uncertain as to what exactly they should be doing and the limits of their role.

Despite this uncertainty, there are many examples of work undertaken by midwives in the area of inequalities in health. The next section explores work undertaken with disadvantaged clients, with reference to specific issues highlighted in recent midwifery literature, in particular: the midwife's remit, what it means to work with women with special needs, midwives as providers of social support, midwives as advocates for disadvantaged women, and midwives' role in parent education.

## 4.4 The midwife's role

### 4.4.1 The midwife's remit

In line with midwifery's philosophy of individualised care, most midwifery literature concerning disadvantaged clients concentrates on individual accounts, or on practical interventions with specific groups. Few take on the broader socio-political issues addressed in Chapter 3. However there are one or two notable exceptions. For example, in their controlled study of social support and pregnancy outcomes, Oakley et al. (1990) insist that the broader political and social issues are central:

> *'Although the policy implications of our findings must be in the direction of promoting continuity of care and a less impersonal and more sensitive ante-natal service, it is important to remember that social policy changes are also needed to improve the health-denying conditions in which many mothers and babies live.'* (Oakley et al., 1990: 161)

Oakley et al. do not identify themselves as midwives, which suggests that midwives feel hindered by a professional identity that discourages active political engagement,

### 4.4.2 Working with 'disadvantaged' clients

In terms of meeting the needs of disadvantaged women, specifically, no single approach dominates the midwifery literature. There appears to be a tension between what might be thought of as structural and individual approaches to disadvantage (as discussed in Chapter 3). The notion of women with special needs is not uncommon in midwifery – the term tends to be applied to groups of women assumed to have the same or similar needs; these may include clinical, social and/or cultural needs. However, alongside this approach, is applied the notion of individualised care which seeks to avoid the stereotyping that can arise when people are grouped into special needs categories. As Kargar and Hunt (1997) suggest:

> *'There is growing recognition that there is no single "best" system of maternity care for all women, and that not only individual women, but also certain groups of women, have "special needs" – while addressing the problems of particular "groups", there must always be an awareness that the women concerned are first and foremost individuals, with their own needs and desires, albeit having many of those needs in common with other women with similar difficulties.'* (Kargar and Hunt, 1997: 2)

The problem with terms like 'special needs' is that they tend to place too much emphasis on the individuals and groups associated and too little on the process by which needs are defined as 'special'. Individuals and groups defined in this way have something in common, they are different from the 'norm' – that is, they are not white, middle-class and heterosexual. Rather than challenging such 'norms', midwifery philosophy and practice prefers to treat such women as having special needs. In our study we prefer to talk about 'disadvantage' and 'disadvantaged' individuals and groups, as such terms are arguably better able to encompass the process by which such individuals and groups become, or are reinforced as, disadvantaged in receiving maternity care. The role of the midwife and other health professionals in reinforcing or challenging that disadvantage is, of course, central.

Whilst most commentators accord midwives a central role in providing care to disadvantaged women, many disadvantaged women themselves may see midwives as relatively less important than other professionals. They may be more concerned with issues such as housing or financial assistance than the specifics of pregnancy and childbirth. This issue is explored further in the case site analyses.

### 4.4.3 Midwives as providers as of social support

Pope et al.'s research into the role of the practising midwife and her continuing education needs (Pope et al., 1996, 1997; 1998a; 1998b; 1998c; 1998d), raises many issues relevant to the present study. In particular, they distinguish between the different areas of care in which midwives perceive themselves to be engaged. Of particular importance is what might be seen as the 'social' as opposed to the 'clinical' role of midwives. Pope et al. report that 61% of the midwives surveyed reported that they provided women with 'social support' during pregnancy (Pope et al., 1998a: 22). Midwives perceived their roles differently depending on whether they worked as community, hospital or integrated midwives, with midwives working in community settings being more likely to report giving social support as part of their role (Pope, 1998a: 22).

Whether or not women expect midwives to give them social support is less clear. Some authors argue that women expect it (Oakley, 1979; Garcia, 1982), whilst others have found that women rated screening and management of physical problems to be far more important (Bryce, 1990). However, recent studies indicate that whether or not they expect it, women given social support enjoy improved pregnancy outcomes (Oakley et al., 1990). In the above studies, who is in the best position to provide social support is not explored; the present study will address this issue.

Whilst social support is frequently mentioned in the literature, the concept is rarely defined. Thoits (1982) distinguishes between two types of support: expressive (sympathy, empathy, understanding, affection, acceptance and acting as a confidant) and instrumental (information, advice and material aid). Our study seeks to improve understanding of the different types of social support sought by different women. Furthermore, drawing on data from in-depth interviews with clients and midwives, it aims to throw light on the process by which such social support is negotiated and delivered.

### 4.4.4 Midwives' role as advocates for disadvantaged women

A key issue in relation to advocacy concerns the question of whether midwives should simply provide immediate care to women with specific needs or act as advocates for them more widely within the hospital. Whilst many articles stress the importance of midwives advocating for their clients needs, for example in highlighting the need for special equipment for physically disabled women, none give specific tips on how to achieve this type of advocacy in a financially pressurised NHS.

One area of importance here is the size of midwives' caseloads. This gap in the literature is surprising given the extra time needed to support women with special needs. There is almost a tacit acceptance that much of this work is performed by midwives in their own time and because they have some special interest in a specific area of disadvantage. Even within articles that describe specific projects undertaken with women with specific needs, there is no mention of caseloads. The Government recently commissioned a review into midwifery staffing ratios and the funding for maternity services (Dimond, 1999: 143). This, together with current policy emphases on inequalities in health, might suggest that greater attention will be paid to the resource implications of caring for disadvantaged women in the future, and is explored in more depth in the case site analyses.

In other areas of public support for people with special needs, specific entitlements are laid down. For example, children with specific learning needs receive a legally-binding statement of special educational need with an allocation of resources. In a recent radio broadcast, a leading psychiatrist, put forward the same argument in relation to people with schizophrenia, asserting that they should have a legal right to appropriate care. Women with specific needs do not, in the midwifery context have special legal rights, and it may be argued that adequate provision is often left to the good will of individual professionals.

Cruickshank and Beevers (1989) suggest that, due to the proliferation of projects in the voluntary sector which only just cope with accommodating the needs of people from ethnic minorities, the NHS is able to perpetuate the absence of co-ordinated, funded and well-thought out provision. The advent of community projects funded through the national lottery could be said to increase this, as does the general trend towards health workers being encouraged to specialise in areas of 'special need' because they have a particular interest in it. Many projects designed to address the needs of disadvantaged women are funded on a short-term basis, and are undertaken by practitioners' working in their own time or rely on midwives being given the appropriate time in the work context within which to engage with them. This issue is explored further in the context of the case sites.

### 4.4.5 Midwives' role in parent education

Another aspect of the midwife's role discussed in the literature on disadvantage is parent education. Particular attention is given to the question of the appropriate balance between seeking to include information relevant to disadvantaged women in mainstream parent education classes and providing specialised classes for such women and their families.

*Changing Childbirth* (DoH, 1993) brought about an increased imperative on midwives to provide information and advice. They have been exhorted to empower their clients to make informed decisions, and parent education has been seen as an important vehicle for achieving this. However, Collington's study suggests that midwives often feel unprepared for their role in teaching about social issues of pregnancy and childbirth in parent education (Collington, 1998a; 1998b). Her respondents stressed that initial midwifery education did not sufficiently prepare midwives for their educational role.

Furthermore, the extent to which it is possible to empower marginalised women through a traditional midwifery education programme remains contentious. Collington (1998a; 1998b) analysed responses from a mixed social group and found that, in general, women benefited from parent education. However, her findings do not clarify whether the small numbers of disadvantaged women in her study (n = 4) benefited. Other studies suggest that parent education for women with specific needs are problematic and that women need to feel that the education is relevant to their situation. Furthermore, midwives often find dealing with mixed groups and trying to meet all their clients' needs very demanding (Collington, 1998a).

This issue has been raised in relation to women with specific needs in a variety of contexts. For example, women who are older, single, lesbian, black, disabled, poor, and those with learning difficulties may feel uneasy in a class full of middle-class, white, married, heterosexuals in their late 20s or early 30s. Some authors suggest that including such individuals in parent education sessions can be difficult for midwifery educators and suggest, instead, that individual sessions in the clients' own homes are more appropriate. However, none of these authors explore the manner in which this may exclude women with specific needs from communities of childbirth. Priestley (1997), writing about a project set up in a area of Bolton with a large Asian population, states that parentcraft sessions for Asian women were well attended due to the fact that it was made clear that a link worker would be available to translate information given by the midwives and health visitor.

The present study attempts to investigate both midwives' and clients' perspectives on the value of different approaches to parent education for women who have special needs – who are disadvantaged.

## 4.5 'Dos and don'ts': the practical focus of midwifery articles concerning caring for disadvantaged clients

There have been a few explorations of different aspects of disadvantage in maternity care. Bharj (1995) and Beech (1991) examine the experiences of ethnic minority women and women living in poverty, respectively, following the well-established recognition of the correlation between low socio-economic class and peri-natal and neonatal mortality and low birth-weight (House of Commons, 1980; Kaminski et al., 1973).

Other work has documented the ways in which specific women or groups may be denied equality of care. Kroll (1990) and Hunt and Symonds (1995) examine the effects of racism and midwives' lack of knowledge about specific cultural beliefs. Reilly (1993) and Salmon and Powell (1998) concentrate on midwives' lack of understanding about the implications of poverty. Dopson (1990) and Wilton (1996) examine prejudicial attitudes towards travellers and lesbians, respectively. Kelsall (1993) and Wright (1997) examine the maternity needs of women with disabilities.

Other work focuses on discrete projects aimed at tailoring services to meet specific needs, including Davies (1997), who concentrates on women living in poverty, Baxter (1995) who focuses on women needing support from bi-lingual workers, and Mir (1996) who investigates an Asian women's advocacy service.

Some literature concerning disadvantaged women attempts to identify the specific knowledge, skills and attitudes needed for midwives to give optimum care to such women. The authors offer advice to others caring for similar groups or report on dedicated projects, often with short-term funds, for example: women with learning difficulties (Dixon, 1997); economically deprived Bangladeshi women (Sen and Holmes, 1996); pregnant smokers (Dunkley, 1997); and abused women (Campbell and Campbell, 1996). Some are concerned with particular stages of pregnancy, again, in relation to particular groups, for example: ante-natal screening and diagnosis in a multiracial society (Schott and Henley, 1996); and pregnancy loss in minority ethnic communities (Bharj and Khan, 1995).

Many books and articles cover a range of practical issues relevant to midwives caring for disadvantaged women or those who need extra support. Whilst the discussion below does not pretend to be exhaustive, the following areas of disadvantage are explored as examples of the issues addressed in the midwifery literature:

- women from ethnic minority backgrounds
- women living in relative poverty
- younger mothers
- women with disabilities
- women with HIV/AIDS
- women who misuse drugs
- lesbian women
- women from ethnic minority backgrounds.

### 4.5.1 Women from ethnic minority backgrounds

The midwifery literature on caring for women from ethnic minorities is, perhaps, the most challenging. Such texts highlight the importance of combating institutionalised racism, prejudices and stereotypes. For example, Kroll states that:

> *'Most experts believe that racism is embedded in the organisational culture of the NHS, which is run predominantly by white, middle-class professionals.'* (Kroll, 1990: 72)

Part of the problem is the language barrier that exists for many ethnic groups. Kroll laments the lack of interpreters available and highlights the lack of knowledge amongst ethnic minorities of tests and services which may be of particular benefit.

In addition to the language barrier, a wider cultural barrier must be overcome. Again, Kroll challenges midwives to improve their knowledge of different cultures:

> *'Midwives know very little about the spiritual beliefs and customs of the different cultural groups within their health authorities.'* (Kroll, 1990: 72)

Kroll suggests that midwives need to know where to look in order to learn:

> *'... midwives rarely consult the groups and advisory centres that exist in the various ethnic communities, although these groups can be a source of advice when midwives are faced with a problem that may be best dealt with by someone from the appropriate cultural group.'* (Kroll, 1990: 72)

Kroll also explores racism experienced by midwives as employees within the NHS, asserting that:

> *'Midwives' beliefs and values are rarely examined at the start of their training, and, in the current economic climate, racial awareness and anti-racist workshops will not feature high on the agenda ... Awareness of racism and inequality should be a strand throughout the educational curriculum ... The ethical and professional implications of our midwifery practice should be constantly reviewed in the light of the society in which we live. This may help to eradicate the prejudice and stereotyping that is found in some maternity units. Midwives must be aware that stereotyping denies the needs of the individual.'* (Kroll, 1990: 73)

Kroll concludes by generating a list of issues which midwives should employ to help them examine their attitudes to individual clients and colleagues:

- *'What attempts am I making to understand the needs of the ethnic population in my area and the midwives with whom I work?*

- *Am I displaying awareness of and respect for different cultures and life-styles?*
- *Do I have preconceived ideas and prejudices, which detract from my efforts to cater for clients' needs and my ability to respect the values of my colleagues?*
- *Am I really listening to the other person's feelings and making an effort to see matters from her point of views?*
- *Am I communicating effectively and is it a two-way process?*
- *Am I taking care not to dictate to and dominate the other person? Is my body language appropriate?'* (Kroll, 1990: 73)

Kroll states that the above is *'a modest start, perhaps, but we have to begin somewhere'* (Kroll, 1990: 73).

Since Kroll's work was published, some particularly important publications have related to ethnic minority issues in the midwifery context. Neile (1997a) and Gerrish et al. (1996) explored the extent to which ethnic minority issues had been included in midwifery curricula. Neile (1997b) suggests some practical tips for midwives working with women for whom English is not their first language:

- *'Using interpreters.*
- *Using advocates or link workers who share the woman's language.*
- *Learning a few useful phrases to help the woman feel welcomed and respected.*
- *Employing more minority ethnic midwives and employing more midwives who are multilingual.'* (Neile, 1997b: 131)

There is increasing acknowledgement of the need for interpreters and advocates, so that clients and professionals may communicate effectively. This is reflected in the Department of Health's (2000a) commitment to increase advocacy provision and a growing body of literature concerning the use of interpreters and advocates in the health services.

Chesney (2000; 1995), recounts her experience of working alongside interpreters both in the UK and abroad. Her work is an unusual example of deep personal reflection and honesty in which she teases out some of the difficulties of working in 'a three-way relationship'. Chesney considers that the catalyst for challenging her own cultural assumptions came through becoming a member of a white minority in her work in Pakistan:

> *'Reviewing my past experiences caring for Pakistani women in Rochdale has enabled me to address my previous complacency, cultural blindness and imperialist approach to care. The spark that ignited the fire of change came from being deposited in the minority position myself.'* (Chesney, 2000: 165)

Chesney discusses the complexities of working alongside an interpreter. One factor she highlights is that of the interpreter commonly sharing the same cultural norms and values as the client, making the interpreter no more 'neutral' or 'objective' than the midwife or client (Chesney, 2000).

It is well documented that it is not uncommon for health professionals to suspect that the interpreter has changed the meaning or emphasis during translation (Chesney, 2000; Teasdale, 1998). Likewise interpreters often found it impossible to merely translate, and sometimes culturally inappropriate. This is also borne out by the case site data.

Wasongarz (1994) suggests the use of a 'transparency' rule whereby the interpreter informs the health professional if a direct translation is impossible or inappropriate and informs them of changes, additions or omissions they make. This is moving towards a model of advocacy rather than simply interpreting, which assumes that verbatim translations are made.

Teasdale gives the following definition of advocacy: *'Advocacy means influencing those who have power on behalf of those who do not'* (Teasdale, 1998: 10). In working with clients for whom English is not their first language the use of a health advocate may commonly include translation, interpretation as well as this advocacy role.

Parsons and Day's (1992) article is interesting in this regard. Their concern with the links between ethnicity and low birthweight, high peri-natal mortality and other negative obstetric outcomes led them to evaluate the potential of health advocacy. Their findings showed a significant decrease in the caesarean section rate for ethnic minority clients provided with advocate input, at one hospital. This was compared with a significant increase in the caesarean section rate for ethnic minority clients at another hospital with no advocacy service. As the authors state, whilst these differences in clinical outcomes:

> *'... cannot be directly attributed to health advocacy it would seem reasonable to deduce that improved communication could have influenced clinical practice.'* (Parsons and Day, 1992: 183)

Schott and Henley (1996) explore some specific health issues relevant to particular ethnic minority groups including: female circumcision, haemoglobinopathies and Tay-Sachs disease. However, whilst offering practical and specific information on caring for people from different cultural groups, Schott and Henley also suggest that students should not stereotype clients, but should *'... find out from each client what she or he really needs'* (Schott and Henley, 1996: xvii). Thus, they attempt to achieve a balance between giving detailed information on different cultural groups and affirming that:

> *'None of us is simply a package of culture. We are all affected by a myriad of different influences and, above all, each of us has our own unique personality.'* (Schott and Henley, 1996: 3)

Schott and Henley highlight issues of ADP, asserting that:

*'Combating institutional racism is a key part of ensuring genuinely equal access to services for all clients and their families.'* (Schott and Henley, 1996: 49)

However, they acknowledge that this can be hard because:

- *'It can be difficult to see precisely how the discrimination is occurring, even when the effects are visible.*
- *Many of the processes involved are well-established and appear neutral.*
- *The negative emotions aroused by discussions of racism can stop people listening properly and thinking clearly.*
- *People are often reluctant to see that their own actions, even though unconsciously, may be contributing to discrimination.*
- *Many people dislike change, especially if they are afraid that it will disadvantage them or make them more vulnerable.'*

(Schott and Henley, 1996: 49)

### 4.5.2 Women living in relative poverty

Few authors in the midwifery literature give a precise definition of poverty, although some acknowledge that it is a relative concept (e.g. Davies, 1997). However, most authors take as an indication of poverty, the fact that someone is living primarily on state benefits, or in particularly deprived areas. In practice, then, the 'common-sense' approach to defining poverty taken by practising midwives may not concur precisely with more 'official' definitions which employ the notion of 'half-average income' (Gregg et al., 1999).

Despite the lack of clarity concerning what constitutes poverty, it is well documented that women living primarily on benefits find it hard to afford the recommended nutrition both during pregnancy and afterwards (NCH Action for Children and the Maternity Alliance, 1995). Evidence shows that women in the lowest socio-economic classes have considerably more risk of peri-natal and neonatal mortality (MacFarlane and Mugford, 1999). It is also known that there are clear links between low-birth weight babies and low socio-economic background (Chadwick, 1994). The health of poor women is seen by many to necessitate increased intervention. However, the precise nature of what this should be is less clear. Furthermore, there is little research evidence concerning the barriers to maternity care for poor women.

Chadwick (1994) advocates focusing on those at greatest risk. She stresses the potential role for targeted ante-natal care to low income women, rather than routine care for everyone, and highlights the importance of appropriate health education which moves beyond blaming individuals for health-damaging behaviours such as smoking and drinking.

Davies (1992; 1997) makes the point that *'poverty divides, not just in economic terms, but also in how social life is experienced'* (Davies, 1997: 50). This 'cultural divide', Davies suggests, creates barriers to access to public services, including maternity services. Midwives working with poor women, therefore, need to make extra efforts to break down barriers by sharing a cup of tea, chatting informally and 'being non-judgemental' (Davies, 1997: 53). Davies argues that midwives need to be self-aware and reflect on the cultural component of being a midwife.

Thus, it is considered important for midwives to understand some of the cultural aspects of women's lives, such as how they do, or do not, have access to social and practical support, and the precise nature of that support. Of particular interest in relation to Davies' study is the high proportion of single women or those living unofficially with a partner in order to claim benefit separately. Davies also reports that many women saw their mothers most days and that the fathers of their children were rarely involved with childcare and *'were marginal to the daily activities of the children, even though they were not in employment'* (Davies, 1997: 59).

Davies is a clear advocate of enhanced maternity input for women living in poverty. She reports on the beneficial effects, both clinical and psychological, of an outreach project which targeted poor women to give them more midwifery care than others. The project resulted in increased attendance at ante-natal classes, a reduction in smoking and a reduction in the incidence of pre-term babies (Davies, 1997: 52). It was supported by a multidisciplinary team in which midwives worked with other professionals, such as teachers and probation workers, to achieve *'a cohesive approach to care in the community'* (Davies, 1997: 56). Given the increasing importance of such multiprofessional team working in the midwifery context, it is unfortunate that Davies offers little discussion of the strengths and weaknesses of this aspect of the project. Chapters 6, 7 and 8 of this report offer further insight into these issues in the context of the study sites.

The Maternity Alliance has undertaken a considerable amount of innovative work concerning the needs of poor women. Their role is largely related to the provision of research and information. They set out both to educate midwives about the benefits available to pregnant and newly delivered women and to offer women direct access to such information through their information line.

Salmon and Powell (1998) suggest that midwives need detailed knowledge of how women in poverty make ends meet in order to advise them appropriately:

> *'Midwives visiting families may find it hard to appreciate the extent to which women have to deprive themselves to make low levels of income stretch. This appreciation is important because it can be reflected in a model of midwifery led care that recognises not only the choices of individuals but how the structural constraints of poverty limit those choices.'* (Salmon and Powell, 1998: 198)

They argue further that:

> *'It is inappropriate for midwives to focus solely on individualistic solutions to the health care needs of women in a lower socio-economic class. A community approach, which includes inter-professional co-operation between midwives, epidemiologists, and other primary health care team members, places individual health needs within a broader socio-economic context. This leads to an improvement in the analysis of problems facing women in poverty. It also reduces frustration as they attempt to deal with social needs, which at an individual level are insurmountable. Profiling communities is an essential part of this process and one in which midwives play a vital role.'* (Salmon and Powell, 1998: 110)

Salmon and Powell offer the following advice to midwives caring for poor women:

> *'Questions during health assessments should focus on the available income women have to keep themselves and their babies healthy. This awareness should translate itself into appropriate health advice as there is no doubt that women will disregard health education if it is presented in an authoritarian way. Even worse, women may view it as a reinforcement of an already vulnerable position as health carers make nutritional suggestions the women know they can not afford.'* (Salmon and Powell, 1998: 110)

Salmon and Powell's advice is particularly important in the light of the work reported here and the findings of Davies (2000). Davies found that few of the poor women she worked with identified themselves as having financial concerns. In the case site studies, unless specifically asked about this issue, women did not raise it. Thus midwives need to be proactive if they are to gain any real sense of women's financial hardship in order to target care appropriately.

There is also an issue about precisely how women living in poverty make choices about what they can, and cannot, afford. This study suggests that poor women who buy cigarettes, drugs and alcohol are, for some health professionals, seen as undermining their status as legitimately 'poor', and as a result are blamed for their health-threatening behaviour. These findings are interesting, given that Chadwick (1994) asserts that such attitudes are now rare. The many reasons why some poor women choose to spend money on narcotics that harm their babies and deny their children adequate nutrition has perplexed researchers, policy makers and practitioners alike. Blackburn (1993), Jones and Macleod-Clark (1993) and Graham (1987; 1993) have helped to throw some light on the issue. Graham argues that:

> *'The limited evidence suggests that cigarette smoking is deeply woven into the strategies women develop to cope with caring and to survive in circumstances of hardship … In talking about smoking in the context of poverty women have described how grinding material hardship gives them and their children little opportunity to take part in the lifestyles that others take for granted. They are unlikely to be able to afford either major household items like cars, telephones and holidays or more everyday experiences like buying new clothes, travelling by bus or having an evening out with their partner. In a lifestyle with little style left in it, smoking cigarettes can be the only item of personal spending and the only luxury.'* (Graham, 1993: 82)

Davies (1997) also found that many women saw smoking as their only pleasure in a harsh existence. The issue caused much discussion between midwives and clients. The health education offered by midwives warning of the perils of smoking in relation to birth weight elicited comments which indicated that some would be pleased to have a small baby because the delivery would be easier. Some women looked for alternatives to this received wisdom, citing friends who had smoked throughout their pregnancy but had produced large babies. Davies does not explore, in any depth, midwives' feelings about their clients smoking, let alone any implications of such feelings for the care they give such clients. The case site analyses attempt to identify such feelings and attitudes amongst students and qualified midwives and explore their implications for the delivery of care.

### 4.5.3 Younger mothers

An issue which came up frequently in the study, especially in Case Sites A and B, was the issue of younger or teenage mothers. Nolan's (1998) article concerning teenage pregnancy is one of the few that, whilst recognising the extra difficulties young mothers may face, acknowledges that some are positive about their pregnancies even though they are not always intended.

Reporting on the Maternity and Women's Health Project in Bolton in which maternity services were poorly utilised, Priestley (1997) reports that one aim of midwives on the project was to reduce the number of babies born to teenage schoolgirls. One method of achieving this was to set up a school-based weekly discussion group at which young people could ask about a variety of health-related topics including pregnancy and birth, contraception, infant feeding and eating disorders. For pregnant teenagers, midwives provided parent education and relaxation, aiming to cater for individual need. This required girls to be released from mainstream education in order to study in a centre, with crèche facilities (Priestley, 1997). This model has been successfully employed in other areas, including Newcastle. However, such projects invariably seem to be run on 'soft money' and are therefore subject to the vagaries of funding cuts (Crafter, 1997).

Baker (1999) challenges the current policy drive towards reducing teenage pregnancies. She quotes a midwife who runs a 'Young mums' group in Oxford:

> *'I really worry about what this new focus on teenage pregnancy is going to do. There are some pregnancies, which would be best avoided, clearly, particularly for very young girls who are just children themselves. But the Government's Social Exclusion Unit has just sent out a consultation document, the whole thrust of which is on prevention. It's a pathologising approach, and I see that as dangerous. It reinforces this culture of disapproval – and their self-esteem is not very high in the first place.'*
>
> (Baker, 1999: 14)

The issue of teenage pregnancy was highlighted in two of the three study sites and is discussed in some depth in the case site analyses.

### 4.5.4 Women with disabilities

Most midwifery texts on the subject of women with disabilities deal with either women with physical disabilities or with learning difficulties. The Maternity Alliance has produced a Disability Working Group Pack (Maternity Alliance, 1994a) which although somewhat out of date, includes advice concerning good practice, as well as a charter for disabled parents and parents to be (Maternity Alliance, 1994b). The issues covered include:

- the information and resources that should ideally be available across the country to disabled pregnant women and disabled mothers
- the importance of service providers playing their part in facilitating independence for disabled people
- the rights of disabled people
- advice on how to effectively include the views of disabled people in service planning and delivery.

Much of the literature points to the importance of midwives becoming knowledgeable about the specific needs of women with disabilities (e.g. Kelsall, 1997). Most provides brief case studies to further midwives' knowledge, and stresses the importance of inter-agency working and liaison with voluntary groups and user-led organisations. However, none suggests how local knowledge bases regarding such organisations should be built up and co-ordinated.

Midwives and other professionals come under fire for their unhelpful attitudes towards women with disabilities. Some articles point to the power imbalances between midwives and women with disabilities, although few give specific advice as to what to do about this, beyond laudable, yet vague, statements such as:

> *'If women with a disability are to feel in control of their pregnancy and childbirth experience, then midwives need to reflect on and evaluate their approach to the service they provide.'* (McKay, 1997: 240)

A number of authors point to the prejudice and discrimination that women with learning difficulties may experience when using maternity services. Booth and Booth (1993) highlight the fact that many people believe that people with learning difficulties should not have children. Their research into parenting by people with learning difficulties suggests that there is no clear relationship between parental competence and intelligence. Thus, they warn that when working with people with learning difficulties, health practitioners must not presume incompetence. They also highlight the fact that parenting skills of people with learning difficulties can be greatly improved by structured training.

A number of articles offer midwives 'practical tips' on giving appropriate care to women with disabilities. For example, focusing on women with learning difficulties, Nixon highlights the importance of breaking down information so that those who find it hard to remember things are not overloaded with instructions (Nixon, 1997). She also suggests that it may be helpful to write things down, as even if the women cannot read they may be able to enlist the help of a carer or friend. Rose (1994), writing about the care she provided to a mother with learning difficulties, describes how she designed a simple feed calculator and communication card which enabled parents and professionals to ensure that the baby was adequately nourished.

Cross (1994) highlights the importance of midwives working with learning disability nurses to provide optimum support for clients with learning difficulties. Wright (1997) describes her work advocating for women with disabilities in hospital and ensuring a more-user friendly service that incorporates physical changes to buildings. She asserts that her managers had been supportive in her goal of creating a climate for change within her unit.

Whilst not a major issue in the case sites, there were a number of occasions where the absence of clear policies and practices in relation to women with disabilities was mentioned by participants.

### 4.5.5 Women with HIV/AIDS

The Royal College of Midwives' (RCM, 1998) paper regarding the care and treatment of women with HIV/AIDS asserts the legal duty and professional responsibility of midwives to care for all women, regardless of health status (RCM, 1998). The paper argues that whilst all pregnant women should be offered HIV testing, this should be voluntary. It highlights the importance of confidentiality, and asserts that HIV status should not be recorded on client-held notes unless the client requests this. The paper recommends that all midwives receive training in pre-test discussion and in the provision of care and support for pregnant women affected by HIV/AIDS. It suggests that universal precaution measures be applied and that women with HIV are advised not to breast-feed.

A randomised controlled study of the universal offering of HIV testing concluded that it was not an intrusive method of offering the test, neither did it increase anxiety or dissatisfaction (Simpson et al., 1998). The researchers report that uptake depended more on midwives' anxieties concerning discussing HIV than on women's perceptions. This is also discussed by Mercey, who laments *'the unwillingness of many midwives to broach the issue of testing'* (Mercey, 1998: 242).

The Department of Health, in collaboration with the RCM, issued a policy on HIV testing for pregnant women (DoH and RCM, 1998). It makes clear that it is a midwife's responsibility not merely to offer but to recommend the test, although the choice remains with the individuals concerned. A more recent document also recommends that all women are offered ante-natal screening for hepatitis B (DoH and RCM, 2000).

### 4.5.6 Women who misuse drugs

A number of projects have been set up to work with women who misuse drugs. Some are dedicated midwifery projects, whilst others are run by other professionals. Priestley (1997) discusses an example in which a midwife worked as part of an interdisciplinary training team which helps to provide supported lodgings for young homeless people, together with sexual health training and social services advice. Priestley states the example of one anecdotal account that highlights the benefits of integrating services:

> *'... a project midwife met a young woman who had been misusing drugs throughout her pregnancy. After several meetings at BYPASS the woman sought advice from the midwife about ways to reduce or stop her addiction and began to make use of the maternity services offered. After several weeks of support from the midwife, she had a normal delivery of a live female infant at full term.'* (Priestley, 1997: 216)

As with many such articles, the author is not specific about the nature of the support needed to achieve this outcome. For midwives needing to learn about these issues it would be helpful to have specific guidelines. This issue is discussed in more detail in the case site analyses.

### 4.5.7 Lesbian women

Whilst no openly lesbian service users were represented in our study, the issue of non-heterosexual identities arose in a number of ways that demonstrate the continued importance of this area of disadvantage and inequality. In some ways, this area seems one of the most difficult for midwives to address. Homophobia is rife within midwifery and as Wilton (1996) has observed, it seems to be accepted in a way that other prejudices such as racism and sexism would never be:

> *'In an era of gradually improving attitudes and services for marginalised groups, prejudice against lesbians (and gay men) remains somehow "respectable". Questions of race and gender are recognised by professional bodies, by central Government, by midwifery curricula and by the press and broadcast media as legitimate causes for concern. But this is not the case for homophobia.'* (Wilton, 1996: 126)

Wilton draws attention to research which:

> *'... repeatedly shows that lesbians who are open about their sexuality receive poorer quality health care in consequence ... due to the homophobia of their carers.'* (Wilton, 1996: 127)

Wilton asserts that midwifery education generally fails to equip midwives to recognise the needs of lesbian clients. It would seem to be important for midwives to understand theoretical critiques of homophobia which see it as a process deeply embedded in social structures, rather than merely individual neuroses. In order to equip students with the necessary knowledge concerning the care of lesbian clients, Wilton states that *'accurate and sensitive input on lesbianism must be a central part of the midwifery curriculum'* (Wilton, 1996: 127). Wilton identifies ways in which midwives should approach clients to avoid assumptions about their sexual orientation and to be inclusive of lesbian clients:

> - *'Do not assume that every woman you care for is heterosexual.*
> - *Respect a woman's right to withhold information about her sexuality.*
> - *Do not pry.*
> - *Be clear when discussing sex; sex between a man and a woman is a different activity to sex between two women.*
> - *Know the contact numbers and activities of local lesbian community groups.*
> - *Be clear about the effects of institutionalised homophobia.'*
>
> (Wilton, 1996: 127)

Wilton also suggests that:

> *'... unobtrusive refinements of routine practice, such as form-filling, discussion of support during labour, giving advice on resuming sexual activity after birth, midwives can signal an openness and readiness to support lesbian women. This openness, while passing unnoticed by most non-lesbian women, will send a strong signal to lesbian clients that their existence is recognised and accepted ... Asking, "I haven't met your partner yet; does he or she work full-time?" indicates that you are not just another blinkered heterosexual.'* (Wilton, 1996: 129)

More recently Kaufmann (2000) reported on a survey of 50 lesbian mothers, arguing:

> *'... while lesbian mothers are generally positive about, and appreciative of, the midwifery care they have received, they also report high levels of anxiety about the implications of disclosure, acute awareness of midwives' personal attitudes and how these can negatively impact on quality of care, and cite examples of discomfort, inappropriate service delivery – and even hostility.'* (Kaufmann, 2000: 116)

Based on the findings of that survey, the RCM (2000b) published a paper on care for lesbian mothers. This recommends change for three stakeholder groups: midwives, heads of midwifery and midwifery educationalists. Recommendations include changes at both structural and individual levels, from the implementation of clear anti-discriminatory policies within trusts and educational institutions to an increased willingness to learn and greater emphasis on reflection concerning personal assumptions and values on the part of midwives. Saffron's (1999) advice to midwives on how to meet the needs of lesbian clients includes similar recommendations.

### 4.5.8 Overview of the midwifery literature regarding the care of disadvantaged clients

The 'dos and don'ts' literature in this section suggests a degree of consensus about the skills needed by midwives working with disadvantaged clients. These include:

- an understanding of the social and cultural context of women's lives
- an ability to use information sources effectively
- an ability to refer clients swiftly and appropriately
- an ability to empathise with the client
- an ability to advocate for the client in relation to medical and other colleagues working in the multidisciplinary team
- an ability to overcome personal and societal prejudices using reflexive practice.

The precise mix of knowledge, skills and attitudes needed will, of course, depend on the precise constellation of disadvantage they are dealing with. For example, the degree to which it is appropriate for midwives to act as advocates will vary. Similarly, multidisciplinary team working will be more important in some cases than in others. The midwife's skill is to know what is appropriate at any one time, in any particular case. Exactly how midwives can be prepared for this is the focus of the present study. The next section examines the educational context and focuses on what the literature says about how far, and in what ways, issues of inequality and disadvantage are currently covered in the midwifery curriculum.

## 4.6 Inequalities and the educational context

This section examines the literature about current coverage of inequalities issues in the midwifery curriculum, and discusses two key issues highlighted as being crucial to debate about the education of midwives in terms of meeting the needs of women from disadvantaged groups. These concern the problems and potentials of different approaches to developing theory-practice links and the importance of reflection.

### 4.6.1 Coverage of inequalities in the midwifery curriculum

Strikingly little has been written concerning how far, and in what ways, issues of inequality and disadvantage are covered in the midwifery curricula. Neile (1996; 1997a) argues that, overall, the coverage of multicultural issues is poor across Great Britain and that the good practice that does exist is the result of the commitment of specific individuals:

> *'The evidence in this research that any claim that midwifery makes to providing planned individualised care for black and minority ethnic women is false. However, there are seeds of hope in the minority of students and teachers who are working against the odds to include issues of race and culture in their curricula.'* (Neile, 1997a: 30)

Furthermore, Neile found evidence of complacency in relation to addressing need:

> *'In justifying the lack of multiculturalism in their curricula, many teachers used the excuse that they had very few ethnic minority clients in their populations.'* (Neile, 1997a: 30)

Neile goes on to challenge such a rationale for non-inclusion of multicultural issues:

> *'... it is at least as important, if not more important, for clients who form tiny minorities to have their specific needs catered for, as they are likely to be isolated and less likely to complain for fear of victimisation. Staff may also have a lower level of awareness and expect clients to conform. Furthermore, educational institutions should be preparing midwives who are fit to work in any environment and not just in their own locality.'*
> (Neile, 1997a: 30)

Gerrish et al. (1996) examined the extent to which pre-registration programmes of nursing and midwifery education prepare practitioners to meet the needs of minority ethnic communities. Minority ethnic respondents revealed problems relating to language, respect and recognition of difference and of cultural need. Practice experience was deemed crucial for students to develop skills and competencies in such culturally-sensitive care, and midwifery programmes were found to have made greater provision than nursing programmes. Furthermore, whilst only one-third of the midwifery teaching staff had had extensive personal development to underpin their teaching about the needs of minority ethnic clients, approximately 66% of midwifery respondents felt that course work prepared students to meet the needs of minority ethnic communities.

Gerrish et al. argue that developing competence in working with clients from particular cultures clearly involves the acquisition of culturally-specific knowledge. However, as important, they argue, is the development of more generic *'intercultural (or cross-cultural or transcultural) competencies'* that can be applied with different cultural groups. The practice setting is seen as the ideal site for the development of such competencies.

However, Gerrish et al. are clear that, whilst students are unable to develop such intercultural competencies without the opportunities that the practice placements provide, such placements do not guarantee that such competencies will be developed, and highlight the importance of preceptor expertise in this area. This issue is addressed as part of the case site analyses.

Another of Gerrish et al.'s arguments relates to the importance of close education-service links if students are to develop intercultural competencies. They point to the importance of clear equal opportunities policies in both settings, arguing for:

> *'... much closer co-operation between education institutions and practice settings in developing equal opportunities and anti-oppressive strategies in an inter-agency context of health care delivery. This might, among other things, include the adoption of a formal policy proscribing verbal and behavioural expressions of xenophobia and racism, applicable to all staff and clients with appropriate mechanisms for its enforcement.'*
> (Gerrish et al., 1996: 141)

Thus Gerrish et al. see the development of intercultural competencies as a structural and organisational issue. They warn against leaving such issues to key individuals, as this tends to both exploit those individuals and marginalise the issues:

> *'The case studies revealed very clearly how particular individuals tend to be responsible for promoting transcultural competence as an issue in professional training. They also indicated how such individuals may be simultaneously marginalised and exploited. They are marginalised in that colleagues feel able to say "that's their bag – let them get on with it – my commitment lies elsewhere". They are exploited in that these same colleagues, and the institutional management are likely to invoke their "good works: when asked to comment on how their programme addresses the needs of minority ethnic clients.'* (Gerrish et al., 1996: 129)

The manner in which individual midwives and/or lecturers assume, or are afforded, expertise in relation to particular groups or inequalities issues in general, is a salient issue for the present study. It is, of course, also of relevance to the manner in which students gain experience. Priestley (1997) explains how she took responsibility for her own lack of experience regarding the care of ethnic minority clients:

> *'Towards the end of my training as a pre-registration student I recognised that I had had very little clinical experience caring for women from different ethnic groups. Aware that there was a high prevalence of ethnic minority clients in some areas of Bolton, I wrote to Bolton Hospitals NHS Trust to arrange a placement.'* (Priestley, 1997: 215)

As Jacob and Watson (1998) point out, Rule 43 of *The Midwives' Rules* places a statutory responsibility on the national boards to monitor practice and assess the quality and suitability of clinical placements for midwifery education programmes. They state that clinical placements are selected on merit of exposing students to specific learning objectives. However, there is still no actual requirement on students to undertake a clinical placement in an area in which they will work with disadvantaged women.

Furthermore, the authors report that although most students had experience of community and labour ward care, only one-third said that they had experience with midwifery-led care; greater numbers were exposed to a hospital model of care. This should be borne in mind when considering exposure to issues concerning women with specific needs. Pope et al. (1998a) suggest that community midwives were more likely to consider giving support to be part of their role. It may well be that students are not having sufficient exposure to midwives who deal with issues concerned with appropriate care to women with specific needs. The present study seeks to investigate this issue further.

Kent et al. (1994) make the point that within midwifery education, students' learning experiences are shaped by the type of service found in that area. This was also found to be the case by Gerrish et al. (1996).

In their evaluation of practice-based learning in post-registration programmes, Fish and Purr (1991) reported that there was a belief that practice experience is intrinsically good. Teachers believed that it was where students could develop clinical competence and specialist knowledge. However, there is no real evidence to show how students learn through practice, or how theoretical education affects clinical effectiveness. Again, this is an issue on which the present study should throw some light.

### 4.6.2 Theory-practice links

The question of how theoretical education relates to practice is an important one, and has received much attention from NHS policy-makers. An NHS Executive (1998) discussion document reviewed a comprehensive range of stakeholder views concerning the relationship between theory and practice. Whilst it did not explore the contested nature of the term 'theory', it made a number of salient points which are relevant here.

The document highlights the important influence of the organisational cultures within the NHS and educational institutions on the relationship between what happens in the university setting and what occurs in the practice arena. It indicates that the transfer of knowledge from research or classroom into practice is problematic. This is particularly the case when knowledge imparted in educational contexts is applied in clinical contexts with a lack of understanding, rather than employed as speculative and developmental, providing a tentative guide to be refined and tested. The document suggests that now that clinical teachers are no longer available, the task of drawing out theoretical principles from practice is often delegated to inexperienced practitioners who may be unable to fulfil that responsibility.

The discussion document also proposes that the perceived lack of relevance and utility of theories advocated for practice is predicated on the assumption that teachers who are no longer in clinical practice have lost touch with practice issues. It proposes that problems in relationships within, and between, sectors of the profession, and particularly between those in practice and those in higher education, were exacerbated by the move of nurse education into university settings and the lack of clarity about the role of clinical teachers.

Others have also written extensively on the theory-practice relationship. Fealy (1997) suggests that in the literature on the theory-practice relationship there is evidence that it is understood in a number of ways. Fealy suggests that:

> *'... there is a tendency to think of nursing as an applied science and to think of practice and theory as separate endeavours where the basis for practice lies in the collective "common sense" understandings of the practitioners engaged in practice.'* (Fealy, 1997: 1061)

Fealy continues:

> *'... attempts to move beyond the top-down approach of science and the over reliance on the [practice] situation as a basis for nursing knowledge have led to the adoption of approaches which have more to do with the complex social activity that is nursing.'* (Fealy, 1997: 1067)

This, Fealy believes, has led to a re-conceptualisation of the theory-practice relationship based on the validity of self-reflection, pointing to evidence of a critical approach congruent with nursing practice as a human and social enterprise that is inherently problematic. This argument supports the view that in the day-to-day world of nursing and midwifery, theory and practice are held in a state of dynamic tension that is necessary for the development of practice (Jarvis, 1992; Allmark, 1995; Rafferty et al., 1996).

Whilst clarification of this conceptual position is important, in Fealy's study, aspects of the theory-practice gap are perceived solely as the difference between the knowledge that educational institutions teach and that which is used in day-to-day practice. Eraut et al. (1995) propose that the term 'theory-practice' gap conveys a number of different meanings. Those pertinent to this study include:

- theory, when referring to text-book knowledge derived primarily from the scientific disciplines, may be disregarded by sceptical practitioners as irrelevant in comparison with that they use as part of 'common' practice
- dissonance between 'idealised' practice as advocated in the educational setting and the practice considered acceptable in most practice settings
- the description of practice in generic terms, giving sets of principles rather than interpretation in specific instances
- theory may refer to a body of knowledge relating to abstract concepts referred to as 'nursing theory'.

In relation to the first point, findings by Eraut et al. (1995) imply that some practitioners believe the solution to the theory-practice gap lies in removing most of the theory from professional programmes. This issue was also of relevance to the present study.

Practitioner's unwillingness to carry out 'idealised' practice may also be predicated on its perceived impractical nature. However, impracticability can be construed as genuine or as a defence mechanism. Students in the present study reported a dichotomy between what was taught in the classroom and what happened in practice.

The meaning of the theory-practice gap is also demonstrated in the present study when students learn about women with certain disadvantages in an abstract manner which ignores the context of their daily lives. Students are left to interpret this information to the care of specific women in daily practice. This type of education also ignores the affective aspects of care delivery and the potential for stereotyping and prejudicial attitudes.

Students in this study did not explicitly report the type of theory-practice gap described in the fourth point, nor did the curriculum analysis indicate widespread use of this type of theory. This is possibly because, on the whole, midwives have observed the experiences of nurses in the development of nursing theory and the use (or misuse) of models and have retained a pragmatic approach to this type of theory use in relation to practice and research (Price and Price, 1993).

However, an understanding of abstract conceptual issues is important when evaluating care provision. So, in this sense, whilst this type of theory may not be used until students have more practical expertise and seniority, it may have relevance for future practice. An example of this from this study is widespread student awareness and criticism of the limited options available to women in relation to individualised care. However, whilst students may have been aware of the discrepancies between theory and practice, they may not have felt able make these criticisms public.

In response to the way in which theory and practice are dichotomised, Eraut et al. (1995) propose a number of means (or 'mediation processes') by which they may be linked. These are expressed in the model in Figure 4.1. In this model, according to Eraut et al.:

63

*'"Theory" includes public theories of nursing and midwifery practice as well as those discipline-based theories and concepts described under the generic heading of scientific knowledge. The boundary between personal and public theories is difficult to delineate, but personal theories normally arise in the context of trying to understand practice by theorising about one's observations and experience, so we regard them as primarily located in that part of the model.'* (Eraut et al., 1995: 110)

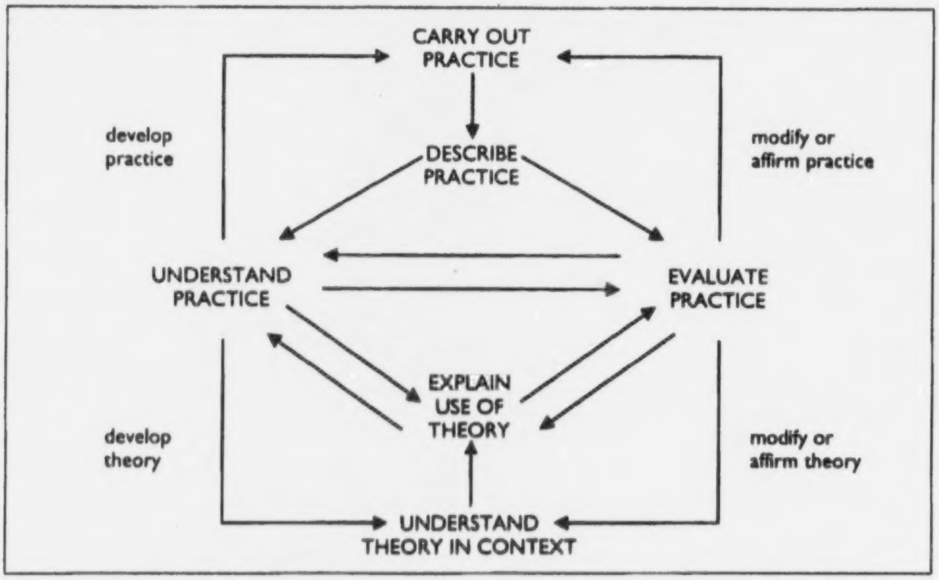

Figure 4.1: A model of processes linking theory and practice (Eraut et al., 1995: 109)

The model offers a structure for identifying aspects of the curriculum that can help to link theory and practice. For example, in the top half of the model 'carrying out practice' and 'describing practice' depend on the student having the opportunity to experience the full range of practice activities pertinent to their future role. Although students in this study achieved sufficient experience to meet course outcomes, practice allocations were often not explicitly planned in a way that would ensure they gained experience with a broad cross-section of clients. However, following Eraut et al. (1995), it is clear that working with a cross-section of clients is not, in itself, enough. Strong theory-practice links depends on university educators and practice preceptors making explicit descriptions of what is happening in care-giving activities and also what might happen in a range of contexts. This allows students to think about practice, *'responding to it emotionally and objectively and expressing personal values in the process'* (Eraut et al., 1995: 111). In this way, practice is made explicit and available for critique.

In the bottom half of the model 'Understanding theory in context' and 'explaining the use of theory' involve establishing the relevance of theory and applying it. The first requires lower-order mediation processes where students may only know where theory may apply, whereas the use of theory in practice requires discussion about how it is used, for example in teachers or preceptors conducting case analysis and/or review of decision-making in specific cases.

The top and bottom aspects of the model meet in the middle to contribute to 'Understanding and evaluating practice processes'. These relate to understanding health care organisations and the ways in which health professionals work, understandings which are fundamental to the subject of this study. As Eraut et al. (1995) point out, this type of process is necessary for evaluation of practice and subsequent decision-making. This aspect of the model requires reflective practitioners who need to develop:

> *'... a critical understanding of service settings, their historical evolution and current culture to appreciate the problems and possibilities of change and the tensions that can arise when changes in practice are proposed.'*
> (Eraut et al., 1995: 112)

This would appear to be a tall order for students who, as Fraser et al. (1998) found, were well prepared at the point of registration to give holistic one-to-one midwifery care to women in normal pregnancy, but had yet to develop skills in caring for women with complications. Given the complexity of issues involved in caring for a range of disadvantaged clients, it is unrealistic to expect that students at the point of registration will be able to fully address their needs. Indeed, as the findings of the present study show, pre-registration students may complete their programme with knowledge of inequalities in health and an understanding of how they impact on health care provision but as newly-qualified midwives, it is unlikely that they will have enough knowledge to evaluate practice in the wider sense suggested by Eraut et al. (1995).

All this suggests that the knowledge, skills and attitudes required to prepare midwives to meet the needs of disadvantaged women are likely to be acquired during career-long activity spanning pre- and post-registration experiences. This is recognised in the report *Fitness for Practice* commissioned by the UKCC:

> *'... assessment of fitness for practice depends on the scope and nature of practice and how this evolves over time – on an individual level as careers progress and on a societal level as health care needs change. Registration then represents an endorsement of the individual's fitness for practice with the proviso that professional updating is an ongoing process.'*
> (UKCC, 1999: 34)

Eraut et al.'s model is comprehensive in identifying the mediation processes for linking theory and practice, but these require flexibility in curriculum structures and teaching and learning strategies. Chapters 6 to 8 examine the curriculum structures of three case study sites to comment on the extent to which the students' experiences enabled them to provide effective care to disadvantaged women.

Mediation between theory and practice also depends on the motivation of lecturers, preceptors and students to accept, or see the relevance of, particular aspects of knowledge or practice. Motivation, in this sense, is part of a person's 'mind set', or personal frame of reference, about the knowledge presented. Eraut et al. (1995) suggest that the best place to start the mediation process is within post-registration education so that preceptors can provide good role models for pre-registration students. They specify that the role model, in addition to having an adequate knowledge base, should have *'the right disposition towards, and understanding of, professional learning'* (Eraut et al., 1995: 115). Chapter 9 examines the developmental implications of the findings of the present study and suggests what changes might be made to midwifery education so that midwives can develop an 'inequalities imagination'.

Eraut et al. (1995) point out that having the 'right disposition' may sometimes mean 'unlearning', which requires a commitment to adopting new behaviour in professional and personal life. At times, it may also mean challenging personal beliefs, the difficulty of which cannot be underestimated. Again, this issue is discussed at some length in the case site analyses and in the concluding chapter.

### 4.6.3 Reflection

Although employed widely in nursing and midwifery education, the concept of reflection has often been used uncritically (Miller et al., 1994, Mackintosh, 1998, Cooney, 1999). Some authors extol its virtue as a means of making sense of practice (Boud et al., 1993, Stuart, 1998; 2000); others conclude that *'the use of reflection as a learning strategy or tool for* *professional development is seriously flawed'* (Mackintosh, 1998: 556). Mackintosh criticises the use of reflection in professional education and practice because of the lack of a clear consistent definition and of a framework through which it can be implemented. She also cites the inability of students to 'think' reflectively which, she argues, cannot occur until they are considerably experienced. Stuart explains that practitioners often respond that they are 'doing it [reflecting] already' but that reflection is a 'loosely-used concept' which is easily assimilated into spontaneous everyday action. However if used as *'a structured, deliberative and conscious way of thinking and acting'*, it can result in learning from experience (Stuart, 1998: 640).

Much attention has been paid to the notion of 'reflective-practice' based on Schön's (1991) work on 'reflection-on-practice' and 'reflection-in-practice'. Reflection-on-practice implies looking back on an experience and critically examining it in order to learn something. Nevertheless, it is by no means straightforward; it requires that deeply-held assumptions, values and beliefs are challenged, which is unlikely to occur in the practice environment where students or practitioners need to feel accepted therefore find it difficult to challenge group norms (Festinger, 1962). However, a qualified midwife, describing self-reflection as enabling practitioners to *'learn to value themselves as significant people with values and feelings which are important in giving care'*, agreed that she also gained insight into many aspects of midwifery care (Jones and Graham, 1994; in Miller, 1999: 19). Also from a practitioner's perspective, Swann (1997) links reflection with the supervisory process and states that without the guidance of a sympathetic, empathetic supervisor of midwives, reflection would not be useful. Others mention the time involved and state that midwives would be reluctant to reflect on practice in written form or in a peer group without specific time being set aside.

Time is also significant in 'reflection-in-action', which is best described as 'thinking on one's feet' with the result affecting the action undertaken. This is likely to be particularly problematic for pre-registration students, not least because it relies on considerable previous experience of autonomous practice action. Maximum supervision at the beginning of the programme, and even minimum supervision at its end, means that the degree of student autonomy and change of action in decision-making is limited because accountability lies with the named midwife mentor.

The concept of reflection-in-action is also problematic for the midwife in that the speed at which most clinical decisions are made denies the opportunity for reflective thinking, and precludes the sharing of that process. Reflection-in-action requires some respite from activity, which means that routinisation must occur in other areas of practice to provide mental space or naturally occurring 'time out' (Eraut, 1994). Jarvis (1992) points out that not only must individual practitioners wish to practice in a reflective way, but that the institution for which they work must support this approach.

These points indicate that it is unlikely that pre-registration students can directly participate in reflection-in-action. Instead, it can occur through their participation in practice activities rather than at their instigation. In the best practice, the student's contribution to clinical decision-making might provide the 'surprise' of which Schön (1991) talks, requiring the practitioner to make tacit knowledge explicit and consider a different perspective from her own. This means that some time may be made for reflection during a potentially habitual practice episode. However, the likelihood of this happening depends on the motivation of the midwife, time pressure of the immediate decision-making and other work and the climate of the organisation.

The above points indicate particular difficulties for students participating in reflection-in-action and the potential of lack of time and proper facilitation for their participation in reflection-on-action. Although there were examples of close collaboration between student and preceptor in this study, it is perhaps unsurprising that, given current constraints, reflection-on-action is the most common form of reflection evidenced in pre-registration programmes.

In Miller et al.'s study of learning styles and the facilitation of reflection, teachers expected that *'reflection would increase understanding, develop self-awareness, enhance ability to analyse, encourage deeper thinking and promote independence'* (Miller et al., 1994: 55). However, the study found that *'teachers were not attempting to pursue individual problems in-depth: they were operating most frequently on the surface impersonal mode'* (Miller et al., 1994: 56).

A series of four stages was described that helped students to link theory to practice:

- describing aspects of their practical experience
- analysing them
- understanding how the situation could have been different
- seeing how they could behave differently in a future similar occurrence.

This process is similar to the mediation processes described by Eraut et al. (1995). However, whilst good for linking theory to practice, there was little evidence of teachers challenging students. In defence of this, teachers in Miller et al.'s study were worried about getting into deep personal matters without the skills to deal with them. This reluctance to probe and challenge students is also evidenced in the present study (see Chapters 6 to 8). Neither should it be assumed that educators themselves are above the need to critically reflect on their own practice.

On a more positive note, Stuart (2000) suggests that the reflective process can usefully be based on the stages of the experiential learning cycle described by Kolb (1984). She believes that learning can occur through reflection but depends on cognitive skills and the skills of the facilitator. Furthermore, as Miller et al. (1994) and Eraut et al. (1995) have suggested, learning through reflection depends on enough time being available.

## 4.7 Conclusion

This chapter has explored relevant health and educational policy debates, and discussed the midwifery context in relation to issues of inequalities in health. It has highlighted how there has been little engagement within the midwifery literature with wider policy debates concerning issues of inequalities in health. However, it has suggested that considerable work explores the needs of groups of women with disadvantaged identities. The review summarised this work and outlined pertinent issues to be taken into account in the curriculum analysis and case site analyses.

The final section explored the extent to which issues of inequalities in health have been included in the midwifery curriculum, and addressed the problem of the 'theory-practice' gap. It then went on to explore the relevance of debates on reflective practice to the study. Chapter 5 presents the findings of the national survey and curriculum analysis.

CHAPTER 5

# PRE- AND POST-REGISTRATION CURRICULA ANALYSIS

## Key Points

- This chapter provides an overview of the findings from a national survey of pre- and post-registration curricula; 54% of institutions returned pre-registration questionnaires and 39% provided information on post-registration programmes.
- Almost invariably, representatives from both midwifery theory and practice were included in curriculum planning teams; students were also well represented. There was, however, a general lack of user representatives.
- The programmes drew upon a range of professional and lay contributors to teaching, although members of local ethnic or religious groups were not well represented.
- Teaching strategies varied, with the most commonly used being the traditional lecture format. Little use of reflection was reported in either pre- or post-registration programmes.
- Within pre-registration programme philosophies, 'individualised care', 'woman-centred care' and 'holistic care' appeared to be the umbrella terms under which inequalities in health and health care provision were addressed. Analysis of programme and module aims revealed similar concepts; however, the focus had narrowed to the level of the individual needs to be met.
- Post-registration provision fell into three types: clients considered to be disadvantaged prior to pregnancy for whom pregnancy may have exacerbated the situation, e.g. pregnancy and disability; clients for whom the disadvantage was specific to pregnancy (e.g. grief in obstetrics); more general issues of social inequality in health (e.g. female sexuality and health).
- When asked what skills and attitudes midwives required to address inequalities in health/health care provision, communication was the most frequently-cited skill, and the most frequently-reported attitudes were a non-judgmental approach and self-awareness. In post-registration programmes inequalities issues were often taught without exploring the role of the midwife. Few actually identified the skills and competencies required in order to better meet client needs.
- Within theoretical and practical assessments, pre- and post-registration students could choose to focus on an area related to inequalities, but this was not a compulsory part of the assessments.
- Only rarely did either the learning outcomes or the assessments require that post-registration students specify, assess or evaluate their role in challenging inequalities or meeting the needs of clients with specific disadvantages.
- Most institutions could offer at least some pre-registration students at least one practice placement which gave them access to women who were likely to experience inequalities in health care/health care provision. However, such placements were not a compulsory part of their education.
- Only two post registration respondents considered that inequalities in health/health care provision featured in the education commission plan.

## 5.1 Introduction to findings

This chapter gives an overview of the national survey of pre- and post-registration curricula. Twenty-five pre-registration questionnaires were returned (response rate: 54%) and 18 (39%) institutions provided information on post-registration programmes.

The analysis of the data from the pre-registration survey provides a context in which to view the nature of the complex relationship between curriculum content and student learning in practice settings and its connection to service users. Pre-registration programmes reported upon were either a Diploma in Higher Education or BSc (Hons), 11 were shortened 18-month programmes and most had been validated within the last three years. Full curriculum documentation was received from nine institutions, with three being analysed more fully within the case site chapters. The six provided by non-case site institutions were used for validation purposes, to determine the extent to which what was reported in the questionnaires was representative of the information in the respective curriculum documents.

Analysis of the data from the post-registration survey provides a snapshot of the type of continuing education offered to qualified midwives as providers of care and who act as preceptors to pre-registration students.

Section 5.2 examines institutional arrangements regarding equal opportunities and anti-discriminatory practices that may impact on the education delivered. The preparation of lecturers and their contribution with others to curriculum development and delivery is the subject of the following section. The education provision identified by respondents as related to inequalities in health and/or health care provision is described and analysed in Section 5.3; the analysis is quantitative and qualitative and considers the type of provision offered, teaching strategies and staff input, client needs addressed, content, learning outcomes and assessment. The characteristics of links with local trusts are described and the type and quality of practice placements in giving pre-registration students access to women likely to experience inequalities in provision are discussed. In Section 5.10 attention is paid to the post-registration provision and the way in which decisions regarding what was on offer were made and factors influencing the midwives' ability to take up these opportunities.

## 5.2 Institutional arrangements regarding equal opportunities and anti-discriminatory practice

The survey covered many areas. Questions related to policy statements, staff interest, responsibilities and staff development, and opportunities for staff and students to discuss their attitudes and experiences in relation to inequalities in health and/or health care provision were included. The following sections address each of these areas in turn.

### 5.2.1 Statements of equal opportunities (or similar)

Over half of the educational institutions reported the inclusion of a statement of equal opportunities or similar in pre-registration curriculum documentation, as part of a general policy. These were slightly more likely to refer to ADP than to equal opportunities. Six respondents reported statements which included both ADP and equal opportunities. Three also included AOP.

Equal opportunities statements related either to university, faculty or school policy in relation to students and staff or in a smaller number of cases to the curriculum itself.

In most cases the university, faculty or school statements of equal opportunities were concerned with recruitment procedures for students but sometimes they also addressed staff issues; for example:

> '... *we are striving for equality of opportunity for students and staff regardless of race, age, religion, gender, sexual orientation or disability and seek to promote freedom of speech and tolerance of differing views.*'

This statement forms an extension to a well-developed university policy, which included a policy statement, and code of practice of how to avoid anti-discriminatory behaviour which staff and students were expected to live up to.

Only two other respondents identified university, faculty or school-based policies that extended beyond recruitment to include the period of education.

Not all curriculum documents included equal opportunities statements. However, respondents from institutions where curriculum did not include such statements indicated that they were working within universities that held such policies.

### 5.2.2 Staff interest/responsibility and staff development

Although just over half the respondents reported having a main person(s) with a special interest or responsibility for teaching about inequalities, only in a third was it thought that staff had undergone specific development. The number of designated people in an institution varied from one or two to one institution where all the module leaders in the department were identified as interested or responsible.

Where only one or two people were designated as having a special interest or responsibility, they were mostly responsible for teaching sociology or related modules. When greater numbers were designated the range of teaching increased to include health promotion, ethics, culture and more specific midwifery issues such as teenage pregnancy and breastfeeding.

Specific staff development consisted of first or higher degrees in subject areas considered relevant. These were grouped mainly around women's health/studies, sociology, health education/promotion, ethics, and psychology. Two respondents also mentioned attendance at study days, and one added that reading relevant articles constituted staff development. Interestingly, the areas of non-specific staff development reported as a way of preparing staff for teaching inequalities in health and/or health care provision was markedly similar to that reported as specific development. The wide range of degree and postgraduate qualifications reported, with social science qualifications dominating, is indicative of the diffuse nature of preparation that educators consider appropriate staff development in this area.

In all cases staff development appeared to be undertaken individually, and even in institutions where larger numbers of staff were designated as responsible for teaching there was no evidence of joint in-service training.

### 5.2.3 Student and staff forums

Respondents were asked whether their organisation provided a forum where either staff or students could discuss their attitudes and experiences in relation to inequalities in health and/or health care provision. Pre-registration student forums for discussion were provided by all but one organisation and six provided formal staff forums.

In the majority of cases student forums were seminars or discussions that formed an integral part of the teaching programmes. Two respondents spoke of weekly practice or reflection sessions as the time when these issues most frequently came up, one adding that second-year students were particularly good at setting up their own discussion forums. One respondent identified group tutorial sessions as the relevant student forum, and one reported a one-off opportunity to discuss these issues with an equal opportunities officer.

Four of the six staff forums used to discuss attitudes and experiences were described as meetings or seminars located within the department; the other two were arranged by the faculty or university. The faculty forum was described as taking place on 'an individual level' with 'the equal opportunities person'.

Forums at department level included various interest groups 'in an *ad hoc* way' and various teachers' meetings and field meetings. Two respondents reported a similar range of opportunities for this sort of discussion including:

- curriculum review meetings
- monthly midwifery team meetings

70

- regular research meetings
- meetings with heads of midwifery services
- module evaluations.

Essentially both student and staff forums at these institutions were not set up specifically to address these issues. However, opportunities for discussion arose within the broader teaching sessions and departmental meetings on an *ad hoc* basis.

## 5.3 Contributors to curriculum planning and delivery

One way in which issues relating to inequalities in health and/or health care could be reflected in educational programmes is through the background and expertise of members of curriculum planning teams and those contributing to teaching and learning.

### 5.3.1 Members of the curriculum planning team

Almost invariably midwifery lecturers and clinician representatives were included on curriculum planning teams together with lecturers from other disciplines – particularly nursing, sociology, psychology and biology. Students were well represented, however, there was a relative lack of user representatives, with only a third of respondents reporting their involvement. Whilst it is impossible to ascertain from these findings how much influence individual team members had on curriculum planning, around half of the teams enjoyed a relatively wide membership.

### 5.3.2 Session/module leaders and contributors to the teaching

In all but one pre-registration programme the curriculum included teaching on inequalities in health and/or health care provision. The majority of these sessions or modules were led by midwifery lecturers or lecturers from other disciplines, such as nursing and sociology, with input from specialist midwives or other professionals. A few respondents also reported other professionals (e.g. social worker, police inspector), representatives from the voluntary sector or members of the community as leading sessions or modules, often conducted with a midwifery lecturer present.

A wide range of representatives from the voluntary sector (e.g. National Childbirth Trust (NCT), disability liaison officers, link-workers for deaf or multicultural issues) also contributed. Less than half the respondents reported drawing on other professionals as contributors (e.g. environmental health officers, race relations, and welfare rights) or specialist midwives (e.g. child protection, travelling families, and drug use). Members from the community, such as parents of babies cared for in special care baby units or members of local ethnic or religious groups and students, were drawn upon the least.

The range and extent of contributors to the teaching drawn from outside the department did not appear to depend on the length of the programme. Some short programmes used a wide range of contributors while some long programmes only used one or two sources, and *vice versa*.

Similarly in post-registration programmes the majority of session leaders for modules/units or sessions/study days were midwife lecturers either leading on their own or with another person. Other leaders included nurse or neonatal nurse lecturers, lecturers from other disciplines, and experts from the practice arena or specialist areas.

The types of 'other' people who contributed to the post-registration provision consisted of other midwife lecturers, nurse lecturers or health professionals such as specialist midwives, nurses and doctors. Other professions allied to medicine (e.g. microbiologists) and agencies that may become involved in some cases (e.g. police and social services) were also represented in individual modules/units. A smaller proportion of provision involved users, lay people, representatives from support groups and from ethnic or minority groups.

## 5.4 Curriculum philosophy, aims and learning outcomes

The majority of respondents identified statements from their curriculum philosophy, aims, and/or learning outcomes as either directly or indirectly relevant to inequalities in health and/or in health care provision. The following sections explore the themes and categories generated for each part of the curriculum in turn.

### 5.4.1 Curriculum philosophy

Taking into account the findings of the literature review concerning different constructions of 'disadvantage' and in midwifery of relevant approaches to inequalities issues, the extent to which curriculum philosophy statements drew on midwifery and nursing philosophies of individualised care was explored. The extent to which notions such as 'equal opportunities', 'anti-racism', and 'anti-discriminatory' practice were mentioned in the programme philosophies was also examined.

Interestingly, the word 'disadvantage' was not used in any of the statements and 'inequalities' was by only two institutions. In these cases reference is made to the need for inequalities to be 'recognised'; the second statement refers to the expectation that students will be taught to 'challenge' such inequalities:

> *'The course planning team recognises that many inequalities exist within our society especially in relation to issues of class, ethnicity and gender. However, we believe that we should strive to treat all individuals equally, with understanding, respect and dignity'* (PR17)

> *'It is also acknowledged that inequalities within our society have an impact on the lives of childbearing women, midwives and the settings in which midwives work. The programme should, therefore, help students to identify and challenge these inequalities'* (PR17)

Though there are more indirect references to inequalities, for example:

> *'Midwives must have the knowledge and skills to offer an excellent service to all, including those least likely to experience excellent public services or a good obstetric outcome for reasons such as social class or ethnic group.'* (PR42)

However, much more common are references to social/cultural diversity but without reference (direct or indirect) to the inequalities that might arise from those diversities:

> *'The midwife's practice should be informed by an understanding of the health needs of society, including socio-economic and transcultural aspects of the environmental factors relating to health.'* (PR10)

All other statements offered by respondents when asked about direct or indirect references to inequalities in health and/or health care provision referred to 'individualised', 'woman-centred' or 'holistic' approaches to care, some quoting directly from, and others clearly referring to *Changing Childbirth* (DoH, 1993).

Several statements referred explicitly to the relationship between the midwife and the woman and/or her family as central to achieving this holistic practice:

> *'Central to the art of midwifery is the relationship between the midwife and the woman and her supporters and the approach, attitudes and sensitivity of the midwife to the psychosocial and physiological needs of the woman during the process of childbearing.'* (PR03)

Other statements emphasised the disciplines necessary to achieve such 'holistic' or 'woman-centred' care:

*'We therefore recognise that midwifery is a combination of art and science bringing together biology, sociology and psychology and other knowledge which is made relevant in the art of midwifery.'* (PR03)

A broader, quantitative analysis of the 53 programme philosophy statements generated four themes:

- the approach to midwifery care, e.g. woman-centred
- client needs to be met
- qualities of the midwife/midwifery care
- recognition of contextual factors within which questions of equality and inequality need to be understood.

Individualised care, woman-centred care and holistic care appeared to be umbrella terms used by the majority of respondents under which practice that addressed inequalities would be carried out. There were few instances where equal opportunities, ADP or social inequalities were overtly stated in curricula philosophies.

As stated earlier, social, political and cultural issues were identified within some philosophy statements as contextual factors that had to be recognised. The concept of recognition here implies, unsurprisingly for a pre-registration programme, that they did not necessarily have to be addressed. However, statements which identified specific needs to be met, such as individual, psychological, social and spiritual were commonly identified, although only one statement included clients' religious, cultural and linguistic needs.

A substantial proportion of respondents identified philosophy statements that related to how the midwife should carry out care. Using 'relevant skills and knowledge', 'a sensitive approach' and 'being respectful and able to empower' were most frequently identified. A few directly addressed issues such as 'avoiding stereotyping', and being able to 'identify and challenge inequalities'. Of course, the degree to which pre-registration students are equipped to challenge inequalities is open to conjecture and is explored more fully in the case site analyses.

### 5.4.2 Curriculum programme and module aims

Analysis of the aims suggested that inequality issues became compartmentalised into specific modules, rather than being embedded throughout the curriculum.

Just two statements from overall programme aims referred to 'equality' or 'inequality' explicitly, one referring to the achievement of equality of opportunity through the provision of maternity care, the other to the importance of developing a midwife who is actively opposed to discrimination in all forms. One institution offered two statements from their programme aims as examples of direct reference to inequalities:

*'To provide opportunities which will equip individuals to become competent in determining priorities in the provision and management of midwifery care for clients and their babies based on individual need of women of diverse cultural, religious, racial and socio-economic backgrounds and in diverse settings.'* (PR26)

*'To enhance the individuals capacity to recognise and respond to the need for, and initiate change positively, effectively and with confidence to meet the demands of, a constantly changing health care system in a diverse and multi-cultural society.'* (PR26)

Following the literature review, our analysis would consider these as indirect rather than direct references to inequalities in that they employ the concept of 'diversity' (in relation to socio-economic background, culture, religion or race) which implies difference but not necessarily disadvantage, a central aspect of inequality. However, the latter statement does draw attention to the role of the midwife as a change agent, a point made in two other statements selected by respondents. This suggests that, for these programmes at least, the midwife, in facilitating change, was considered central to delivering equality of care. Several statements about the need to develop midwives' ability to 'empower' women were offered as 'indirect' references to inequalities in programme aims.

Reflection was mentioned as an example of indirect reference to inequalities in two cases, both in relation to general attitudes and values of the individual midwife and their impact on the provision of care. In addition, being able to practise in different settings and being flexible were identified in programme aims statements as necessary qualities to be developed by midwives in order to deliver equality of care.

Several aims statements addressed specific groups who might be considered to be disadvantaged. Women with disabilities, those with mental health problems and women whose babies required neonatal care were all identified in this context.

The majority of statements offered by respondents in response to the question about direct or indirect reference to inequalities in programme aims tended to focus around the teaching and learning of particular approaches to midwifery and all were considered to be examples of indirect reference to inequalities. As with the statements from programme philosophies, approaches favoured were woman-centred, client-centred, individualised, holistic or needs-centred care.

Most direct references to inequalities were found in the aims of individual modules rather than overall programme aims. Two typical examples of module aims statements offered as direct references to inequalities are shown below:

> *'People with special needs in pregnancy will be considered, e.g. the very young, those from differing ethnic groups, unsupported mothers, women with disabilities, those who misuse substances and the way in which social problems and other events may affect pregnant and non pregnant women and their health.'* (PR19)

> *'To debate and apply concepts of need, equity, demand, power, advocacy and consumerism to the delivery of health care.'* (PR24)

Many aims statements offered as direct reference to inequalities issues were taken from modules addressing women's health issues:

> *'Discuss the inter-relationship between health, gender and culture on women's health in a local, national and international population. Contrast inequalities in health, concept of patriarchy in relation to women's health etc. biological determinism.'* (PR18)

One institution offered three statements from one module, which focused on the decision-making processes and funding of health services as examples of reference to issues of inequalities in health. This could be interpreted as the recognition of inequality being a structural and organisational issue, not simply an interpersonal one.

Other statements offered as examples of direct references to inequalities in module aims tended to cluster around several themes, similar to those found in the philosophy statements discussed above, for example:

> *'To develop the students' understanding of the midwife's role in providing woman-centred maternity care within a wider political and professional framework.'* (PR13)

Module aim statements offered as indirect reference to inequalities issues were not always different from those offered as examples of direct reference. Most referred to the need to understand the broad social and/or cultural contexts within which midwifery is practised, for example:

> *'Midwifery students will look at the family in its broader contexts with the main focus being the application of sociological theory to midwifery practice.'* (PR19)

One or two statements specifically addressed client groups such as women with a disability, and a few respondents saw neonatal care as relevant to inequalities in health.

The themes identified in the aims statements were similar in content to those identified from the curriculum philosophies, although the balance had shifted. For example, woman-centred care, client-centred and holistic care still figured as relevant approaches to addressing inequalities, but the individual nature of the client or care appeared more at a level of needs to be met rather than an overall approach. Addressing individual needs or providing individualised care figured in about half of the respondents' answers to the question on aims. Special needs and meeting different or diverse needs also appeared in the aims of some curricula.

### 5.4.3 Curriculum learning outcomes

The diversity of pre-registration learning outcome statements identified in terms of content and focus was broad and reflected both indirect as well as directly relevant statements. The main themes identified were:

- overall midwifery care approach
- clients' needs to be met
- elements of midwifery practice to be learnt
- qualities of the midwife
- contextual factors
- what the student gains.

Qualities of midwives identified in the learning outcomes were further divided into those relating to communication, professional issues, reasoning skills and awareness.

Several learning outcomes were common to more than one curriculum. Three statements from *The Midwives' Rules* (UKCC, 1993) were quoted almost word for word. The most commonly cited was:

> *'The appreciation of the influence of social, political and cultural factors in relation to health care and advising on the promotion of health.'* (PR12; PR17; PR26; PR31; PR38; PR43; PR45)

Curriculum planning teams for these institutions may have drawn on *The Midwives' Rules* (UKCC, 1993) more heavily than other planning teams. Alternatively, it may be that other curriculum planning teams took *The Midwives' Rules* (UKCC, 1993) into account when planning their curriculum but preferred to develop their own statements.

Fifteen respondents identified at least one learning outcome that they thought was directly relevant to issues related to inequalities. The topics that featured most frequently in these statements were as follows:

- o sociological concepts (n = 11)
- o anti-discriminatory practice etc. (n = 7)
- o special needs (n = 5)
- o health promotion (n = 4)
- o social factors (n = 4)

- attitudes and beliefs (n = 3)
- existing health problems (n = 3)
- individual differences (n = 3)
- individual needs (n = 3)
- abuse (n = 2)
- communication (n = 2)
- referral and other health professionals (n = 2)
- risk and complications (n = 2).

While some statements were clearly directly relevant to the issues in question, most were more general. This was particularly so for statements which dealt with care during 'normal' labour, for example:

> *'Carry out initial and subsequent health and progress assessments of mothers and babies during normal pregnancy and the postnatal period.'* (PR04)

Or with the way in which maternity care was organised:

> *'Discuss the organisation of maternity care and its impact on women, their families and the provision of care.'* (PR48)

However, the more obviously relevant statements related to sociological content, ADP, special needs and health promotion. Those that contained a sociological theme included examples such as:

> *'Critically analyse and apply sociological concepts in assessing and evaluating the needs of families in society.'* (PR05)
>
> *'Be aware of cultural differences relevant to health and health care.'* (PR36)

Examples of statements identified as directly relevant, which specifically addressed inequalities or ADP, included:

> *'Show awareness of equal opportunities policies and anti-discriminatory legislation in relation to race, colour, gender and disability.'* (PR36)

One curriculum, in particular, had three learning outcomes that followed on from one another and brought these issues into the student's sphere of individual responsibility in a way which could not be misinterpreted:

> *'Understand the personal attitudes, institutional policies and societal frameworks that produce and perpetuate inequalities and disadvantage.'*
>
> *'Recognise their own attitudes and behaviour and how these may contribute to inequality and disadvantage in society and in service delivery.'*
>
> *'Begin to adopt anti-oppressive attitudes and develop professional strategies that promote equal opportunities.'* (PR43)

Learning outcomes identified as directly relevant and which addressed women and families with special needs included:

> *'Develop communication skills appropriate to women with special needs during pregnancy.'* (PR19)

Health promotion was also a popular area for identification of statements of relevance.

Similarly, issues related to inequalities in health and/or health care appear to be fairly well represented in post-registration learning outcomes.

In most cases, learning outcomes were expressed in terms of what the midwife was expected to be able to do by the end of the module, unit or session. Thus, the midwife was expected to be able to identify, understand, explore, discuss or critically analyse either a particular social or cultural issue that had an impact on care or an aspect of care in relation to the needs of clients experiencing specific disadvantages. Often, learning outcomes clearly showed that midwives were expected to understand the disadvantage experienced by some clients and show an awareness of cultural diversity and/or other forms of inequality. However, there was no mention of the role of the midwife here or of the specific skills and competencies she was expected to acquire in relation to these clients' needs. In fact, only 13 of the 62 provisions included learning outcomes that addressed the role of the midwife and the specific skills and competencies required of her by the end of the module or session.

Much less common in both pre- and post-registration programmes were learning outcomes that explicitly mentioned reflection and the need for students and midwives to reflect on their own attitudes, beliefs and practices and how these might impact on the care given to clients experiencing specific disadvantages.

## 5.5 Key knowledge, skills and attitudes

Most respondents thought that the pre-registration curriculum identified key clinical or contextual knowledge and/or skills needed by midwives in relation to addressing inequalities. The picture for key attitudes was slightly less clear, with fewer reporting that the curriculum identified key attitudes in relation to this. The following sub-sections describe the key knowledge, skills and attitudes identified by respondents.

### 5.5.1 Key knowledge

The most frequently mentioned topic, by eight respondents was 'cultural issues', followed by 'communication' mentioned by six respondents; 'ethics', 'health care provision', 'individuality' and 'stereotyping' were reported by four respondents each. A range of other topics were cited by at least one respondent and these overlapped to some extent with the key skills and attitudes identified in the following sections. For example, 'counselling' and 'respect' were identified as topics to be covered. Specific issues such as prejudice, substance misuse and childbearing, gender, sexuality and learning disabilities were also mentioned.

### 5.5.2 Key skills

Fifteen respondents identified communication as a key skill essential for midwives addressing inequalities in health and/or health care provision. Other skills such as counselling skills, assessing client need, empowerment, evaluating care, interpersonal and management skills were also mentioned, but much less frequently.

Again there was some overlap with knowledge and attitudes. For example, one respondent identified 'knowledge of support groups, ethnic support and link workers' as a skill, while another identified 'non-stereotyping'. Nevertheless, the majority of skills identified related to practical aspects of midwifery practice that could contribute to addressing inequalities, such as 'problem solving', 'teamwork' and 'dissemination of information'.

### 5.5.3 Key attitudes

Of the 15 responses, the most frequently reported attitudes thought to be as essential for midwives addressing inequalities were 'a non-judgemental approach' and 'self-awareness', both of which were mentioned by five respondents. One respondent reported that students should:

> *'Acknowledge their own pre-existing preconceptions.'* (PR36)

Recognition of individuality, and openness/acceptance were the next most frequently mentioned attitudes. One or two respondents also mentioned non-stereotyping, unprejudiced and anti-discriminatory attitudes. Four reported that although the key attitudes needed by midwives addressing inequalities issues were not made explicit in the curriculum they could be achieved by less direct means, for example:

> *'No but [the curriculum] does include students examining their own attitudes.'* (PR13)
>
> *'No. The curriculum encourages open attitudes and acceptance.'* (PR24)
>
> *'No. However, it would be assumed that as qualified nurses, students would be familiar with the notion. The curriculum would supplement this focusing on midwifery practice.'* (PR25)

## 5.6 Teaching content

In post-registration provision the amount and quality of information reported on teaching content in relation to inequalities varied. From a curriculum analysis alone, it is not possible to gauge exactly how modules addressed issues of inequalities, what approaches were being taken or in what depth issues were covered. However, some institutions managed a greater degree of integration than others.

The degree to which the provision addressed the role of the midwife is also important. The majority of relevant provision listed by respondents did not address inequality directly: that is, neither inequalities in general nor specific disadvantages were the focus of the provision. Those that did address such issues can be divided into two categories: broad-based sociological or anthropological units and more midwifery-focused provision.

Perhaps not surprisingly for post-registration midwifery education, there is a greater provision aimed directly at midwives than there more general sociological or anthropological provisions. In only two out of eight such provisions did there appear to be any opportunity to examine the role of the midwife. However, it appears that even when the role of the midwife was a focus, the way in which this role was examined varied enormously. In some programmes, there was simply a general reflection on the implications for midwifery practice (e.g. sexual abuse and awareness for midwives; care and management of people with HIV/AIDS). In others, there was a more sustained examination of ethical and legal issues (e.g. substance misuse). Finally, some programmes examined the specific skills and competencies required by the midwife (e.g. grief in obstetrics).

For pre-registration programmes all but one respondent provided information on teaching content specific to inequalities contained in sessions, modules, or units. Two explained that the issues were addressed across the programme.

### 5.6.1 Content of sessions

In pre-registration curricula individual sessions were more likely to address discrete issues or client groups and modules tended to cover broader subject areas. The most commonly reported relevant sessions had a sociology or social theme, including:

- race and ethnicity
- inequalities in health
- attitudes and health beliefs
- culture and faiths/religions
- effects of social class.

The next most frequently reported topics for sessions addressed specific groups of women, e.g. substance misuse; teenage pregnancy; women with disabilities; women who experience domestic or sexual abuse' women with HIV or sexually transmitted diseases; and women who are homeless or travellers.

The remaining sessions related to a range of topics and issues, some related to specific groups or conditions, for example, women in prison, but many addressed wider issues which were made relevant to inequalities, for example, fertility, health screening.

### 5.6.2 Content of modules

Within the modules reported as relevant, sociology or society-related content figured most frequently, followed by health promotion modules and those that applied psychosocial approaches to midwifery. The titles of the remaining modules covered a wide range of topics, from issues relating to women and women's health generally, to complex obstetric care and care involving risk, to those related to meeting common needs in normal pregnancy or common physical and mental disorders.

### 5.6.3 Clients whose needs were addressed

Pre-registration respondents reported a number of client groups whose needs were addressed; those mentioned more than once were:

- ethnic minorities
- women who misuse substances
- women with physical disabilities
- women who have suffered abuse
- teenage mothers
- working class women
- HIV positive women
- women with mental illness
- women living in poverty
- travelling women
- women with learning disabilities
- lesbian women
- women with STDs
- women coping with bereavement.

The most frequently mentioned group was ethnic minorities, and in some cases, specific groups (Asian, Afro-Caribbean) were specified as relevant to the local area. However, attention to this issue was not evenly spread across institutions and some made no reference at all to this group of clients' needs.

This finding is perhaps surprising in the light of the literature review, which suggests that there is now a good deal of material on which to draw. Indeed, for some years now, research has clearly identified the need to incorporate ethnic minority issues more fully into midwifery curricula (e.g. Gerrish et al., 1996).

Three respondents replied in more general terms (e.g. all clients), and one replied general maternity service users, in cases where modules referred to were more general than others (e.g. choices in maternity care; attitudes, beliefs and motivation in health).

In post-registration provision specific client needs were mentioned in association with 70% of the total number of relevant modules. Clients who experience 'social deprivation' were most well catered for, with ethnic minorities coming second, but nevertheless some way behind. Less frequently mentioned but in significant numbers were the disabled, teenagers, and clients with HIV, followed by substance misusing clients, clients with babies with special needs, lesbian clients and clients suffering physical abuse. In addition to these specific client needs, seven modules were more generally aimed at 'disadvantaged women'.

It is difficult to assess from the responses in the questionnaires, the extent to which constellations of disadvantage are addressed. It is also important to reflect on the different types of disadvantage being clustered together in responses. Some categories of clients specified can be understood as being already socially disadvantaged in a way that may simply be exacerbated by becoming pregnant (the socially deprived, ethnic minorities, those who are HIV positive, those misusing substances, etc.). Indeed, those experiencing particular constellations of disadvantage might be expected to have more difficult pregnancies and complicated births than those not disadvantaged in such ways. However, others listed here as disadvantaged may be disadvantaged only in relation to the specific experience of pregnancy and childbirth. For example, women with babies with special needs and women suffering unexpected loss in pregnancy may otherwise be relatively privileged individuals. This distinction raises some interesting questions and issues for midwifery education and practice. It may be that those who are deemed disadvantaged in this rather narrow sense are easier to cater for as their needs can be more clearly specified, giving rise to clear health care targets, policies and practices that midwives can learn about and implement. In contrast, clients who are deemed disadvantaged in the broader sense may be more difficult to cater for as their needs may be diverse and complex, especially where there are constellations of disadvantage. In these cases, midwives may be left with an awareness of the problems but little idea of the implications of awareness for their practice with individual clients.

Only six of the 12 modules listed as referring to specific clients needs refer to needs of those who may be considered disadvantaged prior to pregnancy but whose disadvantage may be exacerbated by pregnancy. Examples included 'pregnancy and disability' and 'substance use'. A further three refer (albeit implicitly) to those whose disadvantage may be specific to the pregnancy, such as 'high risk childbearing' and 'grief in obstetrics'. The final three modules could be interpreted as referring (albeit implicitly again) to more general issues of social inequality in health and health care that have implications for midwifery, including 'female sexuality and health' and 'socio-cultural context of birth'.

Eleven study days, sessions and 'self-directed study' provision focused on specific client needs. Again, a range of types of disadvantage are represented; for example, it is interesting to compare two provisions: 'smoking cessation' and 'meeting the needs of ethnic minority clients'. Women who smoke may be considered disadvantaged in relation to pregnancy and childbirth compared with non-smoking women in the sense that their chances of having an underweight baby are higher. However, their disadvantage is the result of an addictive behaviour and is clearly different from that experienced by ethnic minority clients whose disadvantage stems from racism and discrimination. It is not clear from the questionnaire responses the extent to which such differences in issues of disadvantage and inequality are recognised and addressed.

In the vast majority of cases, the titles of modules offered as relevant to issues of inequalities suggested that the teaching was concerned with a specific aspect of midwifery care rather than with clients experiencing particular forms of disadvantage. However, the data suggest that issues of inequality and disadvantage may be well-integrated into the relevant module or session. A good example here would be 'enabling successful breastfeeding' (POST04) where socially deprived women are listed under 'clients' needs addressed'.

### 5.6.4 Clients whose needs were not addressed

Decisions regarding the type and content of post-registration provision are discussed in Section 5.10.1. Within the pre-registration curriculum seven respondents felt that not all needs were being addressed and reported the following omissions:

- travellers
- many small minority groups, e.g. travellers, Polish, Somali etc.
- single, unsupported mothers and lesbian couples
- perhaps a broad perspective on all groups who are disadvantaged socially, physically or emotionally
- elderly (touched on only within sessions on family care)
- clients who are para- or tetra-plegic
- women who are blind.

One respondent wondered whether the requirements of the groups in particular were met through an individual basis within the clinical environment, adding that:

> *'To spend time on teaching around the many and diverse groups that fall into these categories would be too onerous within the current educational climate.'* (PR26)

Another respondent echoed these sentiments in explaining a gap they had identified in their curriculum regarding women with disabilities:

> *'... there seems to be so many other issues that are more common and need to be covered within the curriculum.'* (PR48)

Although not reporting an omission to their curriculum, two respondents felt that coverage depended on the client groups encountered by students when in practice, i.e. that the teaching in class or practice could respond to these particular groups as they arose. Given the many issues to be incorporated into the midwifery curriculum, it is perhaps unsurprising that in some areas (especially those with little social deprivation and few ethnic minority clients) inequalities issues are not seen as a priority. Programme leaders have to be selective and to make difficult decisions about what to include and what not to include in the curriculum.

These points also raise the interesting question of how teaching and learning about inequalities should be addressed. Should it be based around the needs of specific groups/types of disadvantage (perhaps those represented in the local community), or should it be more general in nature? The success of the former approach depends on the transferability of knowledge and approach to other situations, while the latter could leave students to apply general principles (such as respect for difference, anti-discrimination etc.) to the specific needs of disadvantaged individuals that they come across in their practice. This is a key issue for this research and is discussed further in the case site analyses and the conclusion.

## 5.7 Teaching strategies

Almost all pre-registration modules used lectures as their main strategy, followed by discussions, seminars and group work. Role plays/simulations appeared to be used across the sample, whereas reflection and the use of reflective diaries were mentioned by only two respondents. Perhaps surprisingly, the practice placement was mentioned as a key teaching strategy for only three modules.

An analysis of the pre-registration module reading lists showed that of the 14 most frequently-occurring references, only *Inequalities in Health* (DHSS, 1980), the most frequently quoted, is not related to childbearing.

A variety of teaching strategies were reported in post-registration provision. Again, the most frequently-used teaching strategies were lectures, seminars and discussions. About half the respondents also reported using group work, tutorials and workshops. Reflection was reported to be used by six respondents across a total of 13 modules. The use of techniques which involved discussion of case study material, scenarios or critical incidents were less commonly used but were reported by two or three respondents each.

Specific exercises, such as 'values clarification', or worksheets and learning packages were reported by individual respondents only, along with strategies involving the use of experts or users. However, the low frequency of reports of the use of experts or users as a teaching strategy is misleading as Section 5.3 shows that experts from other disciplines, user groups or the practice arena were used more often than this suggests.

The teaching strategies used for the post-registration sessions/study days mostly consisted of lecture and discussion, or 'question and answer', which was popular with one respondent in particular; a few also used group work, tutorials or workshops. The use of video, problem-solving and key lectures was also reported for individual sessions/study days.

## 5.8 Assessment

Responses here suggest that whilst pre-registration students were able to choose to cover inequalities issues in both theoretical and practical assessments, in very few cases were they required to do so.

In post-registration provision most respondents were vague in specifying relevant assessments; these required that the midwives demonstrate awareness, understanding and critical analysis of issues and problems related to inequalities. Only rarely did assessments require that midwives specify, assess or evaluate their own role in challenging inequalities or in meeting the needs of clients with specific disadvantages. As with the much of the pre-registration provision, whilst there was opportunity to choose to undertake an assignment related to inequalities this was not a requirement.

Six pre-registration programmes did contain either theoretical or practice-based assessments that required students to engage with these issues. There were more opportunities to choose to do so in theoretical than in practice-based assessments, although most thought that the key attitudes would be assessed within practice based assessment.

### 5.8.1 Theoretical assessments

The theoretical assessments in which pre-registration students could choose to engage with issues related to inequalities in health and/or health care provision, ranged from seminar presentations, poster presentations, essays, literature reviews and the preparing of teaching sessions, through to major projects and dissertations. Of 17 respondents who reported that students could choose a related topic in these assessments, most reported between one and four assessments that could be adapted to the topic area in this way.

Five of the six respondents who reported that students were required to undertake an assessment which engaged with these issues identified three or four assessments which were relevant, while the sixth respondent identified seven assessments.

However, it was usually the case that only one or two of these assessments were clearly related to inequalities. For example:

> *'Presentation on an in-depth (research-based) aspect of communications in a multi-racial society, promoting holism in midwifery plus written analysis.'* (PR18)

The other assessments were taken from wider areas, such as health promotion or a specific aspect of care, which could be linked to inequalities if the student chose to take such an approach.

Sociology, health promotion and issues related to the social context were most commonly reported as topics for assessments which required the student to engage with issues related to inequalities.

### 5.8.2 Practice-based assessments

Twelve respondents reported that students could choose a practice-based assessment that required them to engage with issues related to inequalities in health and/or health care. Those identified were non-specific assessments such as reflective diary, profile or essay, case or care analysis, or critical incident. Two respondents also identified assessment of skills such as communication, and assessing and meeting individual needs.

Six respondents identified more specific practice-based assessments, requiring students to engage with the issues in question, which all were required to complete. Identification of needs and recognition of factors that influenced need or care requirements were most frequently reported.

Examples of how specific some of these practice-based assessments were in relation to needs and client groups are shown below:

> *'The use of appropriate and effective communication skills: Discussions with the woman are sensitive to her cultural and religious beliefs. An anti-discriminatory, non-judgemental approach is used at all times.'*
> (PR20)
>
> *'Assessment of midwifery skills includes booking interviews ... Identification of emotional, cultural and social needs and factors. Giving appropriate ante-natal advice, e.g. parenting, health education ...'*

## 5.9 Practice placements as opportunities for learning about inequalities issues in pre-registration programmes

Respondents were asked about their links with local trusts and the opportunities such links provided for practice placements that expose students to disadvantaged clients and thereby enable them to acquire relevant knowledge and skills to meet such clients' needs.

### 5.9.1 Characteristics of links with local trusts

While five respondents reported links with just one or two trusts, the majority reported that their institution had practice placement links with at least three trusts; five reported links with between seven and 10 trusts. Although respondents were not asked to do so, eight identified a range of types of service delivery within their link trusts, e.g. GP unit, midwife-led unit, consultant-led, community-based teams, etc.

Most respondents also volunteered information on the social, ethnic, and urban versus rural mix in the local populations. The majority reported diverse populations in terms of social or socio-economic mix, and the same number reported urban and rural representation within their link trusts. Just over half the respondents also reported ethnic diversity within the population, with a further three reporting that ethnic groups were represented but as a minority.

Five respondents reported high or comment-worthy rates of drug misuse; three reported high rates of teenage pregnancy and two mentioned homeless women or travellers as characteristic of the local populations of at least one of their link trusts.

### 5.9.2 Opportunities for practice placements of relevance

Opportunities for students to undertake at least one practice placement which gave them access to women who were more likely than most to experience inequalities in health and/ or health care provision were not always provided.

Nine respondents reported that such placements were provided for all students, including two who reported that students could also request a particular placement. Providing placements for all students and on request was usually made possible because of the diversity of the local populations of link trusts. Three respondents reported that such placements were arranged only if the student requested it and another reported that such placements were provided for some students only; two of these acknowledged that variability in the suitability of some placements, due to the local population, could leave some students lacking such experience. However, swapping students around, or placing them in at least two trusts during the course of the programme, were reported as ways to get around this limitation.

Respondents reported on different strategies by which students gained relevant experience through their practice placements:

> *'Some students request/arrange placements to specific areas as part of community experience or part of project work, e.g. groups for hearing children of deaf mothers.'* (PR44)

Other examples of special requests from students included: placements with specialist midwives for homeless or substance misusing clients, and inner city experience. However, two respondents pointed out that provision of such placements was not currently a priority:

> *'... It is not the first consideration. We have high student numbers and it would not be possible to take this into account for all.'* (PR10)

Five of the eight respondents who answered in the negative to this question had done so not because there was no opportunity to arrange a practice placement giving particular access to these women, but because most of their students would come across them during the course of their placements. For example:

> *'Most localities where students are allocated for clinical experience provide a broad range of clients from the indigenous population and from ethnic minority groups. This also covers the whole social stratification of society.'* (PR26)

One other respondent also qualified her negative response as follows:

> *'Not specifically, though community experience is undertaken in at least two different areas throughout the course to endeavour to expose the student to different social groups.'* (PR04)

Therefore, when all explanations for these placements were taken into account, the opportunities for students during their practice placements were more positive than at first sight. Most of the institutions that responded could offer at least some, if not all students, at least one placement which gave them access to women who were more likely than most to experience inequalities in health and/or health care provision. Again, issues of programme time-scales, resources and priorities are important here.

## 5.10 Provision of relevant post-registration education and factors affecting uptake

The type of post-registration provision offered may influence the role of the midwife in her delivery of care, but just as important is the effect that such a preparation may have on her ability to support students in clinical practice who are learning to work with women from disadvantaged groups. Therefore, the type and amount of post-registration provision offered and access to it are of significance.

The 18 respondents reported a total of 112 relevant initiatives between them, but the spread was not even, with just three institutions accounting for 43% of total provision.

Whether this picture is representative of real differences in provision across the sample, or whether it represents different interpretations of what constitutes a focus on issues of inequality and disadvantage, is not clear.

### 5.10.1 Types of relevant post-registration education provision

Four main types of post-registration education provision were reported: modules, units, study days and sessions. Modules were the most commonly mentioned, followed by study days, units, sessions and 'other' forms of provision, both of which were 'self-directed study'.

Modules and units were analysed together as there seemed to be little difference between them; both ran over at least one semester and were taught on a weekly basis for about three hours per week. Of this aggregated total of the relevant modules and units, 62% were run by just five institutions. It is important to note that some institutions were consciously integrating inequalities issues as part of the overall curriculum philosophy and that, in such cases, few specific inequalities-related modules or study days may be recorded.

The length of relevant sessions within modules or units varied between two hours to full-day sessions. In addition to this provision, a student seminar paper on 'inequalities in health in relation to pregnancy' and a dissertation on 'meeting the needs of ethnic minority clients' were also put forward as relevant. The respondent offered both sessions as self-directed study as part of larger modules but no other provision was offered.

The relevant education provision has been grouped into seven major categories:

- midwifery care
- health promotion/education
- specific groups
- professional practice
- social science
- aspects of abuse
- neonatal care.

Individual Board programmes were named but not analysed due to lack of detailed information.

Nearly half of the provision was identified as addressing the issues either directly or both directly and indirectly, with the remainder being identified as addressing them indirectly. However, there was no obvious distinction between those identified as directly addressing inequalities issues and those identified as indirectly addressing these issues. For example, some respondents identified provision addressing drug or substance misuse as directly addressing the issues in question, whereas other respondents identified such provision as only indirectly addressing them. The same was true for topics such as ethical and legal issues in midwifery, and infant feeding versus breastfeeding.

### 5.10.2 How decisions regarding post-registration educational provision were made

The responses here were split between those that emphasised the influence of the purchaser, or service side, through collaborative meetings with the education side and those that emphasised the influence of the 'provider' or educational side.

One respondent's clear statement about how decisions were made summarises the complex process:

*'Post-basic educational provision has become purchaser driven and therefore decisions regarding what post-basic education to provide is in response to what the purchasers want. Alongside this is the ideas put forward by the midwifery lecturers and practitioners. Post-basic educational provision would also reflect national developments and current thinking with regard to midwifery care. Also taken into consideration are recommendations for post-basic education put forward by the ENB/UKCC.'* (POST46)

Only two out of 18 respondents felt that inequalities in health/or health care provision featured in the education commission plan. Even then this was not specifically but as principles, or with an expectation, that the needs of the local population were met.

Six respondents felt that there were issues to do with inequalities that were not adequately addressed in post-registration provision in their area. Only three mentioned specific client needs in this context; these included young homeless parents, women with special needs, disabled women, travellers, women with mental health problems, women experiencing domestic violence and women from ethnic minorities.

### 5.10.3 Access to post-registration education

There was considerable variation in relation to midwives having time off for post-registration education. When they had to pay for their own studies, the sense of inequalities being a specialist area may have been reinforced. Most post-registration education was accessed at local universities and fees were funded through 'non medical education and training' monies. However, eight respondents reported that other (non-contracted) opportunities existed locally for midwives, either organised by the local trust, another local university, or voluntary organisations.

Two interesting points can be drawn out from respondent's additional comments:

- the existence of certain education provision does not necessarily imply popularity or perceived relevance by midwives; take-up may be low or issues go in and out of fashion
- there is the question of priorities in post-registration provision.

For the service provider, education that contributes towards safe delivery may have to take precedence over education regarding inequalities in midwifery care, especially where resources are constrained.

## 5.11 Validation of questionnaire data

As a means of validating the data from the 25 questionnaires for pre-registration provision, six curricula provided by non-case site institutions were used to determine the extent to which the questionnaires matched the information provided in these curriculum documents. However, because of the breadth of the questionnaire and the extent of the detail which respondents included in their answers, the validation was limited to a review of the programme and module learning outcomes only.

The review showed that all statements reported in the questionnaire were quoted verbatim from the curriculum documentation and, in every case, all direct or indirect statements pertaining to inequalities in health and health care provision were included. Programme outcomes often and inevitably mirrored the UKCC competencies, which address inequalities in health or health care provision indirectly. The extent to which module or unit learning outcomes were reported in the questionnaire demonstrated that they were under-represented in some cases; it is impossible to know whether the respondent's concept of disadvantage excluded certain groups such as those from different cultures, or whether statements were omitted by mistake. However, in some cases, reported learning outcomes might have under-represented provision, when compared with that identified by the researcher analysing the curriculum documentation itself. This could be the result of error or, more likely, of the respondent defining 'relevant provision' more narrowly than the researcher.

The post-registration provision sample was small. Just 18 institutions responded to the questionnaire, representing 39% of the population targeted, and curriculum documents were received from only five institutions. Therefore the findings are not necessarily representative of all post-registration midwifery education provision on inequality. However, responses were, in general, both full and informative, and consistent with the content of the curriculum documents where available, enabling a detailed qualitative analysis of the actual education provision on offer.

## 5.12 Discussion

### 5.12.1 Pre-registration programmes

The findings of the national survey of pre-registration curricula provide a valuable overview of the context of midwifery education before a more detailed discussion on the effectiveness of midwifery education in preparing midwives to meet the needs of women from disadvantaged groups is explored in the case site chapters.

An examination of curricula philosophies showed that individualised care, woman-centred care, and holistic care appeared to be umbrella terms under which practice that addressed inequalities in health and health care provision was carried out. There were only a few instances where equal opportunities, ADP or social inequalities were overtly stated.

This individualised care approach was also reflected in programme and module aims, although this tended to be expressed in terms of specific needs to be met. Mention of, or attention to, the specific needs of ethnic minorities was not universal across institutions, with some making no reference to this client group. This is perhaps, surprising given recent research findings (e.g. Gerrish et al., 1996) and the UKCC position that issues of cultural diversity should be recognised and appreciated in midwifery curricula (UKCC, 1998).

An examination of module programme and module aims also provided some evidence that inequalities issues are often compartmentalised into specific modules rather than embedded throughout the curriculum. Modules identified as most likely to be addressing inequalities issues tended to be the sociological or social science modules.

Respondents identified knowledge of cultural issues, good communication skills and a non-judgemental attitude as central aspects of the education needed by midwives attempting to deliver equality of care. However, there was no direct link to assessment criteria. Indeed, it was rare to find a case where students were actually required to address inequalities issues directly in either theoretical or practical assessment; rather, respondents reported that students were able to request or choose to do so. Similarly, students were not required to undertake practice placements which gave them access to women who were more likely than most to experience inequalities. Although in the majority of institutions respondents reported that they were able to offer such experience for some students there was no guarantee that this would take place.

The survey covered a range of pre-registration midwifery education programmes differing in length and level. It may be that the length of the programme affected the depth or the breadth of teaching on the issues in question. It could also be argued that short programmes were planned on the assumption that students would already have covered some material in nurse education. Although it is not within the scope of this project to make a distinction of this kind it nevertheless remains a pertinent question.

### 5.12.2 Post-registration provision

A number of important findings and insights have been gained from the analysis of the post-registration questionnaire. These concern the following:

- definitions and understandings of inequalities and disadvantage as applied to midwifery clients and midwifery care
- approaches to teaching about inequalities and disadvantage
- the significance of the exploration of the role of the midwife.

#### 5.12.2.1 Definitions and understandings of inequalities and disadvantage as applied to midwifery clients and midwifery care

There are several points to make in this context. First, respondents made very different interpretations of what was required from them in their questionnaire responses. Some interpreted the topic of inequalities very broadly and included a large number of provisions as relevant whilst others included only those that explicitly covered inequalities issues, usually in the module or session title. This research seeks to identify the widest possible range and diversity of coverage of the issue. In this sense, the fact that some respondents defined inequalities provision very narrowly means that the cases analysed here are probably an under-representation of what is on offer overall.

The analysis found two quite different understandings of what constitutes disadvantage or inequality in relation to midwifery care. In particular, it was possible to distinguish between two groups of clients who were deemed disadvantaged:

- those who could be thought of as disadvantaged prior to pregnancy and whose disadvantage might be exacerbated by pregnancy and childbirth (the socially deprived, ethnic minority clients, clients with disabilities etc.)
- those deemed disadvantaged only in relation to the specific experience of pregnancy and childbirth, but who might otherwise be relatively privileged individuals (clients experiencing loss in childbirth, those experiencing post-natal depression etc.).

The analysis suggests that it is often perceived to be easier to meet the needs of the second group, as their disadvantage is related to specific conditions for which specific treatments, policies and procedures can be learnt and practised. Those clients experiencing disadvantage prior to pregnancy may also experience what may be termed 'constellations of disadvantage', for which there are no such clear-cut policies, procedures and practices. This issue is further explored in the analysis of the case study data in Chapter 6.

#### 5.12.2.2 Approaches to teaching about inequalities and disadvantage

Similar to the pre-registration analysis, a tension was found between 'integration' and 'separation' in the teaching of inequalities issues. Some institutions offer individual modules or sessions that dealt with specific inequalities or forms of disadvantage and others prefer to see the issue as something that should be fully integrated into all sessions and modules, in line with the philosophy of 'individualised care'. As some clients experience 'constellations of disadvantage', the integrated approach may work better, enabling midwives to see the whole person, rather than defining her by her specific disadvantage/s. After all, there will inevitably be overlaps between some ethnic minority clients and those experiencing social deprivation. Similarly, clients experiencing social deprivation may also misuse substances or be nutritionally deprived. There may be a tension here between the overall ethos of midwifery education that prioritises and promotes the philosophy of individualised care and the need to address specific types of disadvantage separately and in some depth through individual modules and other types of educational provision. The prioritisation and promotion of individualised care could imply that such constellations of disadvantage are recognised and catered for, although whether this actually occurs is debatable.

Again, this is further explored through the analysis of the case study data.

A further finding concerning the approach taken to teaching about inequalities is that only very rarely was this reflected in learning outcomes and assessment. Similarly, only rarely was the issue in the foreground from the identification of initial aims and objectives through specification of clients needs being addressed, to content, learning outcomes and assessment. Only in the modules: 'preparation for parenthood in a multicultural society' and 'the care and management of people with HIV/AIDS' was this level of integration achieved.

Thus, as with the pre-registration provision, this analysis of post-registration provision suggests that commitment to examining inequalities issues may be being undermined by its absence as a compulsory part of the assessment.

### 5.12.2.3 Exploration of the role of the midwife

As with the pre-registration provision, analysis of post-registration provision suggests that inequalities issues were taught mainly through broad-based sociological or anthropological modules. These were not directly aimed at midwives, and the role of the midwife was not covered. The analysis did reveal a number of explicitly midwifery-focused modules, but even in these cases, the role of the midwife was explored in more or less depth across the sample, with very few actually identifying the specific skills and competencies needed by midwives.

The role of the midwife in relation to inequalities in health and/or health care is, of course, a central issue for midwifery education and practice. It may be that midwives who are learning that particular inequalities exist, but are not acquiring the knowledge of what their role in challenging those inequalities should be, will feel unclear about exactly how to meet their clients' needs. Again, this is further explored in the case studies.

## 5.13 Conclusion

Inequality issues featured quite strongly in the majority of pre-registration curricula covered by the survey. However, the model adopted by most institutions was one of individualised care which, whilst requiring a recognition of difference and diversity amongst clients, did not necessarily recognise structural aspects of inequality or explicitly demand ADP. Perhaps, most importantly, however, even where institutions were keen to emphasise inequalities issues in their programme curricula, only rarely were such issues a compulsory part of the assessment. Furthermore, ensuring that all students had access to practice placements that would give them the necessary experience to address inequalities issues in their practice was rarely a priority. Rather institutions worked on the basis that students would gain such experience by default due to the diversity of the local population. Overall, the curriculum analysis suggests that whilst the commitment to addressing inequalities in the midwifery curriculum is strong and the content often full and varied, this is somewhat undermined by the failure of institutions to make practice and assessment in this area compulsory.

Overall, the analysis of post-registration provision suggests that provision is patchy with just a few institutions providing the majority of relevant modules and sessions. Within this, there are both broad-based sociological and anthropological modules and midwifery-focused modules but in neither case are inequality issues a compulsory part of the assessment. Furthermore, the specific responsibilities of the midwife in relation to both the recognition and challenging of inequalities is rarely addressed in either content or assessment. As will be seen in subsequent chapters, these are areas where we feel the education of midwives can be improved.

### Key Points

- Case Site A was in an area with relatively low levels of social deprivation. The midwifery education department was small. The pre-registration midwifery programme was three years in length.
- Curriculum documentation clearly indicated that the concepts of inequalities were introduced at an early stage, with the needs of specific groups being addressed later. However, there was no clear consensus between lecturers and students on where, in the curriculum, issues of inequality were taught. Whilst there was potential for written assessments to address inequality issues, this was not compulsory.
- In common with Case Sites B and C, many students reported the value of inviting user representatives into the classroom to 'make real' specific inequality issues, thereby enhancing the students' understanding.
- Both lecturers and students talked about 'reflection' as a useful device for exploring inequalities issues. However, there was some dissatisfaction from students when reflection was used in an unfocused and non-systematic way.
- Lecturers generally agreed that it was desirable for students to experience a range of community practice placements in order to work with service users from diverse backgrounds. This did not always happen, and was a finding across all case sites.
- Students felt that lecturers needed recent experience of practice if they were to ensure that theory and practice were properly linked.
- Students expressed dissatisfaction with the timing of the largely theoretical sociology module as it was early in the programme, when they had minimal practical experience on which to draw. They were also concerned about the lack of midwifery-specific issues and the module's interprofessional nature. These comments were akin to those at Case Site B, in relation to a similar module.
- A clear understanding of the midwife's role, boundaries and relation to others in the multiprofessional team were considered important across all sites, in relation to dealing with issues of inequality.
- There was general agreement that 'equality of care' meant meeting the specific needs of women and their families, in line with the philosophy of individualised care. This was unique to this case site. Central to this was knowledge of the social/cultural context of women's lives.
- Many respondents deemed good communication and listening skills, together with a non-judgmental attitude to be crucial. Respondents at Case Sites B and C held similar views.
- Examples of unequal care were cited in the following areas: care of non English-speaking service users; attitudes towards younger mothers; and access to services such as the triple test, which had to be paid for.
- Respondents raised differences between the 'functional' nature of hospital midwifery versus the more 'holistic' style practised in the community. Again this finding was common to all sites.

## 6.1 Introduction and background to Case Site A

Case Site A was located in a town with a low incidence of social and economic deprivation and an ethnic minority population of 9%, which is above the national average.

A nearby university provided educational provision for this case site. The midwifery education department was small in comparison to Case Sites B and C, and staffed by educators and lecturer-practitioners. The pre-registration student body comprised approximately 50 students on pre-registration programmes. The department was in a transition from a four-year to a three-year pre-registration programme; Years 2, 3 and 4 were all on a four-year programme, while the most recent intake of students were enrolled on a new three-year curriculum. The four-year programme began with shared teaching alongside nurses, then became more midwifery-focused. The new programme followed a similar format, although the multiprofessional and shared learning strand ran throughout and had been expanded to include physiotherapists and occupational therapists.

At the time of the research, there was no 18-month programme at this case site. The development of an 18-month curriculum was just being completed and shortly due to be implemented.

Due to the small size of the midwifery department, students from different years knew each other and lecturers knew all the students. Data collection was facilitated by the relatively small size of the department which made it made it easy to network and to get a feel for the place beyond the interviews with students and educators. The majority of lecturers and students were white, and most were British.

The midwifery unit at this site served a large geographical area, with approximately 6,000-7,000 deliveries per annum. There was an extensive ante-natal service, including clinic, day assessment and admissions. The unit had a specialist consultant in a major complication of pregnancy and attracted a lot of referrals because of this.

There was a large delivery suite, a separate observation area for high-risk intensive midwifery care and three ante-natal/post-natal wards. In one ward care was provided for women having medical/social terminations as well as for those perceived to need intensive midwifery care; for example, drug using clients, those with physical disabilities etc.

Other areas of the maternity unit included:

- breastfeeding drop-in clinic
- special care baby unit (SCBU)
- a volunteer support service for parents with a baby in special care
- parent education room
- management and administration offices
- community midwives' office.

Two midwives staffed the breastfeeding drop-in clinic three days a week, providing support and information. The service was well-used by women both on the post-natal wards and at home; for example, on the day the fieldworker visited, 17 women visited the clinic.

In addition to the breastfeeding clinic, other services available were:

- parent education (including specialist classes for multiple pregnancy and multiparous clients)
- an informal drop-in education class for teenage parents
- a support service for parents with a sick newborn.

Midwives also offered a service for any woman who wished to talk about her birth experience retrospectively.

Staff at the maternity unit were predominantly white British, as were their clientele. Interviews were conducted with midwives, lecturers, students, other service providers and women clients at this site. Participant observation was carried out in both educational and service settings. In addition, qualitative curriculum analysis was undertaken.

## 6.2 Curriculum analysis of Case Site A

This section gives an overview of the specific ways in which inequalities in health/ disadvantage were addressed by the curriculum at the case site. Data sources for this analysis included: the telephone questionnaire completed by a midwifery lecturer prior to the start of the field work, and the curriculum documents provided by the educational institution. Data were also collected during observation of teaching sessions and from students' written assignments.

The pre-registration programme about which the respondent chose to talk during the telephone interview was a modularised honours degree for non-nurses. A number of philosophical statements were selected from the curriculum documents by the lecturer as being indirectly related to inequalities in health and health care provision. These specifically mentioned meeting individual women's spiritual, social, cultural and emotional needs plus the midwife's role in advocating for the woman's right to respect, privacy, dignity and to make informed choices. Respect for others was extended to the contribution that other professionals and lay persons make to the care of women and their families.

These statements suggest that the midwife was seen as an advocate, responding to women's needs, wishes and preferences. It is, perhaps, therefore surprising that the statement from the curriculum documents which explicitly mentioned the midwife's role as *'an advocate, leader and political activist in order to influence maternity care'* was not selected by the respondent as relevant to inequalities. This may have been because, in this case, the philosophical statements were given to the researcher over the telephone, rather than by the respondent filling out the questionnaire in her own time. A further reason might be that the respondent perceived the achievement of *'acting as an advocate, leader and political activist'* as beyond the reach of students preparing for initial registration. As Jenkins (1995) states, only recently have qualified midwives learned to challenge systems, and they still lack activity on the broader political front. Furthermore at the time of this study it was not a required outcome of UKCC Rule 33, 3c (UKCC, 1998).

The respondent also did not report as relevant the curriculum statement concerning professional accountability and responsibilities in terms of students' contribution to obstetric and medical care. This is worthy of note since the module, which was based around the notion of addressing challenging situations in midwifery practice, conceptualises those at risk of inequalities in health/and or health care provision as including women in high-risk obstetric and medical complication categories.

### 6.2.1 Main features of the pre-registration curriculum

The main features of the three-year pre-registration curriculum at Case Site A can be summarised as follows:

- biology, psychology and social studies were undertaken in the first two years, in the last year the emphasis was on management, and working in a multiprofessional team
- content was organised to move progressively from exploration of the role and skills of the midwife through to investigation of situations that involved *'gradually increasing risks to the childbearing woman and her family'*
- students spent approximately 50% of practice time in community placement
- ten modules were shared by a number of professional groups including occupational therapists, physiotherapists, and adult, mental health, children's and learning disabilities nurses.

All modules contained associated key transferable skills.

92

### 6.2.2 Key findings of the analysis of pre-registration curriculum documentation

The key findings of the analysis of the three-year pre-registration curriculum documentation can be summarised as follows:

- programme and module learning outcomes closely reflected the philosophy
- twelve out of a total of approximately 30 modules were identified as having direct outcomes relating to inequalities in health and/or health care provision; sociologists, psychologists, physiologists, occupational therapists, physiotherapists and nurse lecturers taught five of these modules
- midwifery lecturers were present on every module team, across the multiprofessional and shared learning modules; however, seminar leaders for midwifery students within each module may have been from any discipline, selected at random
- two of the 12 module assignments specifically required inequalities in health to be addressed
- module learning outcomes in relation to transferable skills required students to clarify personal values; however teaching and learning experiences did not specifically state how this would occur, or how this would be assessed
- key attitudes contained in clinical competence statements were assessed; a small number of competence descriptors specifically addressed inequalities issues, but most were generic in nature, hence the lecturer asked to select the statements may not have considered them in relation to inequality issues
- the content of the module which explored midwifery in challenging situations included women with high risk medical and obstetric conditions, women with physical and/or mental disabilities, bereaved women and women in lesbian relationships; the 'challenge' in these cases was ambiguous – depending on the context under discussion, this could have been taken to mean a challenge to women's health or wellbeing and/or challenges to midwives' attitudes and behaviours, and/or to service provision
- non-professional contributors included parents of infants admitted to the SCBU, a mother (and a midwife) with multiple sclerosis and a representative from a women's refuge
- midwifery lecturers had undergone staff development in their particular area of interest, which included teenage pregnancy, sociology, ethics, psychology, women's issues and feminism.

### 6.2.3 Exemplar of a module addressing the issue of inequality

The module selected as an exemplar for Case Site A was midwifery-focused and addressed different dimensions of child-bearing; it was taught at the end of Year 1. From the module outline, the content aimed to provide different perspectives on parenting and explored historical, social, cultural and religious influences; skills in advocacy were also included. The teaching and learning experiences included workshops and small group work. The assignment set for this module was *'Discuss the influences (both positive and negative) on the childbearing family's experience of health care during pregnancy, labour and the puerperium'*.

One of the key transferable skills identified in the curriculum document as a learning outcome was self-management. The text reads *'... ability to examine and clarify personal values and beliefs'*. However, this was not followed through within the specific assessment marking criteria. Furthermore, there were no specific practice competencies associated with this module.

A teaching session exploring parenting was observed on this module. This small group session challenged students to think broadly about families within an historical, social and cultural framework, by giving an overview of approaches to parenting through the century. The session also incorporated visual aids, in particular books about parenting from different eras and a video about two families' different approaches to parenting. Students were encouraged to contribute their own beliefs and experiences, which in part challenged traditional views of parenting. There were some examples of students challenging the views of other students.

Analysis of two post-registration modules provided:

- a theoretical and ethical base for learning in the workplace
- assessment in the workplace, which demonstrated an expectation that practice was anti-discriminatory.

These two modules, which are the equivalent of ENB 997, prepared qualified midwives to facilitate learning, supervise, and assess learners in the workplace. Their use has widespread potential for highlighting the importance of ADP, although its potential could be improved by making compulsory the assessment statement *'acknowledge and respect the rights of service users and learners, and value their differences'.*

## 6.3 Key themes and issues from the research data

This section is an in-depth exploration of the key themes and issues which arose from the case site analysis. This drew on both interview and observational data from both the education and practice areas. The Table 6.1 summarises the data collated.

| Type of data | Description | Number | Duration (hours) |
|---|---|---|---|
| Interview | Focus group with midwifery students | 1 | 2 |
| | Interviews with midwifery students | 5 | 9 |
| | Interviews with preceptors | 5 | 11 |
| | Interviews with service users | 16 | 30 |
| | Interviews with midwifery service managers | 2 | 3 |
| | Interviews with midwifery tutors | 2 | 3 |
| | Parent education specialist midwife | 1 | 1 |
| | Recently qualified midwife | 1 | 1 |
| | Preceptor's student | 1 | 1 |
| | **Subtotal** | 34 | 61 |
| Observation | Classroom observation | | 18 |
| | Practice observation | | 29 |
| | **Subtotal** | | 47 |
| **All data** | **Total** | | 108 |

Table 6.1: Data collated at Case Site A

### 6.3.1 Reflections on inequality and disadvantage

Chapter 3 explored some of the many ways in which issues of disadvantage and inequalities can be framed, and suggested that the way in which practitioners thought about these issues may well have an impact on their practice. Thus, in order to gain a working knowledge of the way in which midwifery managers, midwives, lecturers and students thought about these issues, such interviewees were asked to reflect on the meaning of terms often associated with inequality and disadvantage. They were also asked to consider how they might apply these terms within the midwifery context. The terms were: 'equality of care', 'inequalities in health', 'inequalities in health care provision' and 'disadvantage'. Flash cards were used as prompts to their reflections. There was a reasonable degree of consensus in the responses.

In particular, there was general agreement that 'equality of care' did not mean giving everyone the same but rather it meant meeting the specific needs of women and their families, in line with the midwifery philosophy of individualised care. The following quotation is typical:

> *'It doesn't mean the same care. It means best quality care to each individual woman depending on her needs. It might mean many different numbers of hours, for instance, for different women.'* (Clarissa, community midwife)

Shirley, an educator, seemed to agree with this notion and suggested that it was about the ability to make choices and to be treated as having equal importance and status as other women. She also stressed the importance of understanding the cultural context within which midwives are looking after women, providing *'... care that is tailored to the individual needs of those who are depending on you'*.

Another educator also understood equality of care within the context of individualised care and cultural context, but seemed to consider the two as separable and to believe that individualised care was likely to be the more effective approach:

> *'Equality of care to all women has to mean individualised care because ... for example, you get people from the same ethnic or religious group even, you can't make any assumptions that their needs are going to be the same. So without individualised care you can't guarantee that you give people equality of opportunity.'* (Saskia, educator)

Indeed, Saskia felt that 'individual' should be her 'watch word'. She felt that whilst certain groups were recognised as having unequal opportunities and therefore outcomes, it was important not to stereotype people but *'to look at people as individuals'* instead. In response to the prompt 'disadvantage', her response was similar:

> *'It could be any single one of us in any set of circumstances "The disadvantaged". I think you would have to look at individuals again and their context.'* (Saskia, educator)

In line with her commitment to the individual, Saskia was extremely reluctant to talk about or name particular groups who might be experiencing inequalities in health or be disadvantaged. She felt strongly that inequalities can arise:

> *'irrespective of socio-economic grouping ... you can have people on high incomes who look as though they have all the major advantages but in fact, because of their lifestyle, they may in fact be working themselves into inequalities in health. It is individual again'.* (Saskia, educator)

Saskia's comments are interesting and worthy of reflection. Whilst recognising that some people have more advantages, such as higher incomes, than others, she wants to avoid looking at inequality or disadvantage in any way other than within the context of the individual case or individualised care. Her responses raise interesting questions about the balance between structural and individual accounts of inequalities and disadvantage, and therefore about responsibilities in overcoming them. These issues were raised in Chapter 3, which explored some of the complex issues involved when juxtaposing different conceptions of disadvantage. This issue also arises in Case Sites B and C and is explored further later in the report.

Felicity, a lecturer-practitioner, who also subscribed to a view of equality that means looking at everyone's individual needs, felt that this practice could be well-served by 'team

p - 95

midwifery'. However, she was aware that team midwifery was seen by some as resulting in the provision of unequal care, as some women were seen as gaining at the expense of others. This point may be reflected in what a midwifery manager, said about 'equality of care':

> *'I think that means making sure that everybody has the same high standard of care rather than some women having [pause] … In terms of continuity, for example, some women having access because of who they are or what they know, or how they can use the system, having access to a higher level of continuity than other women. I think it is making sure that they are all able to access the service properly, that they know what is available, that we are aiming to give the same standard of care to everyone.'* (Sue, midwifery manager)

Sue spoke again of her concerns that some women may receive care at the expense of others when asked about 'inequalities in health care provision'. However, others responded to this question by saying, much more directly, that they did not feel that all women received equality of care. A community midwife spoke of women who did not speak English:

> *'I don't think the women in my caseload get equal care … I hope I give equal care at my ante-natal clinic. I know in the delivery suite everybody is at fault because the communications network falls flat if they don't speak English. We don't have any translators that come into the delivery suite with them, so they are dependent on family members and so, for a lot of girls, if that is their first time experience, that can be incredibly daunting.'* (Jean, community midwife)

Despite the assertions of some respondents that translators were available and could be called upon if needed, others, such as Jean above lamented the lack of their provision. The research evidence suggests that the guidelines in relation to the provision of care to minority ethnic clients proposed by Kroll (1990) and colleagues such as Neile (1997a; 1997b) were not being implemented in Case Site A.

Another community midwife responded by saying that she thought equality of care should mean *'you treat all women equally and that therefore everything should be available to all women'*. However, she felt this was not the case and spoke about inequalities in terms of access to ante-natal screening, in particular, the triple test:

> *'In some of my women's cases there is a problem with the money side. Like you have to pay for the triple test, and a lot of my ladies won't go for it because they have to pay for it … You have to pay for it and get yourself there to another hospital and some of my ladies have never even left [this city] let alone tried to find somewhere else … The triple test here is £17.50. I rarely get anyone taking up that because of the cost.'*
> (Jackie, community midwife)

Felicity, a lecturer-practitioner who ran a teenagers' group, spoke of the service received by teenagers, whom she felt did not receive equality of care, and who were not, in her opinion, treated with respect. Like many of her colleagues, she drew on the concept of individualised care. A parent education specialist midwife, also spoke of the need for individualised care in her work:

> *'I've had people who, for instance, a girl in a wheelchair, deaf people, blind people, people for whom you have to go the extra mile in a class setting. You've got to be prepared to set up something individually. I'm not sure that we have still cracked that nut really. They do feel, I'm sure, excluded. We've gone some way down the line but not fully. I'm quite interested to see that health education don't print the book in other languages.'* (Gemma, parent education specialist midwife)

Gemma's comments regarding the difficulties of providing inclusive parent education classes are borne out by the research evidence (Collington, 1998a; 1998b). Like Gemma, some commentators advocate providing individual parent education classes for people with special needs, although the issue of how such an approach might lead to further marginalisation is unexplored in the literature. Furthermore, despite Gemma's good intentions, in Mander's (1997) view, her use of the word 'girl' would denote a difference in status and immaturity which together demonstrate an unequal power relationship.

Students' views largely reflected those of their midwife mentors and lecturers, emphasising individualised care, rather than the same care for all. A student towards the end of her basic midwifery training expressed this particularly well:

> *'It doesn't necessarily mean that all women's care should be the same. It means that all women should have equal opportunity to have the care that suits them. I have to tell you, I am doing my dissertation on institutionalised racism so I have been looking at it. And I think a lot of people make the mistake that "We do this care for everyone and therefore it is equal" but you have to take into account individual circumstances and all the rest of it.'* (Catherine, student)

Another student nearing completion of her training who had come to study in Britain from overseas, concurred with this:

> *'... it doesn't mean that all women get the same. It must mean that women get different things, according to what they need, because they are all individuals. But in the reality, how can you actually do it?'* (Natalie, student)

Interestingly, Natalie understood equality of care issue as a *'very English thing, because of the NHS'* and doubted that it could survive in this 'capitalist world'. She suggested that in countries where private medicine is dominant, there is no pretence at such equality of care – people receive the care they can afford.

When asked about what they understood by 'inequalities in health' and 'inequalities in health care provision' in the midwifery context, participants tended to name particular groups who might experience such inequalities: 'social classes 4 and 5', 'minorities', 'the homeless' and others with complex 'social problems' were all mentioned. Catherine, a student, said that this concept made her think of her first-year sociology module, where students were introduced to inequalities issues. Within this module, it was felt that particular groups did not always know what was available to them and therefore their choices might be limited. A midwifery manager also spoke of these problems:

> *'... I think that is where, for some reason ... where they don't have the same access to the same standard of care to others, leading to poor outcomes for them. It may be because of their socio-economic group, their educational background, they don't know what is available.'*
> (Sue, midwifery manager)

The issue of the degree to which clients of caring professionals are able to understand and make the choices available to them has been reflected on at length in the literature (Brechin, 2000). Consequences for education are such that midwives and midwifery students should be encouraged to implement and reflect on practice which constantly addresses the barriers which may exist in relation to particular service users.

The attitudes of health professionals were deemed, by many participants, to be a major factor in bringing about inequalities in health care provision. This reflects discussions in the literature which draw attention to problematic aspects of the power relationships between service users and professionals in a variety of contexts (Brechin et al., 2000). However, most interviewees who mentioned this aspect of care talked largely about their colleagues' attitudes, values and behaviours, rather than their own. In this context, Felicity, lecturer-practitioner, gave an example of unequal treatment of a teenager:

> *'... one of the teenagers, a few weeks ago, rang because her baby was sick and the GP said "Can you bring the baby to the GP clinic?" It was the middle of the night, and he said, "Well, get a taxi." She said, "I haven't got any money", and he said, "Do you smoke?" so she unfortunately said "Yes". So he said "I am not coming", because he felt that she used her money inappropriately.'* (Felicity, lecturer-practitioner)

Felicity said this kind of attitude encouraged women to be dishonest in order to access the care they need, a practice she did not feel comfortable with. Veronica, another lecturer-practitioner, also spoke of such judgemental attitudes amongst her colleagues:

> *'That brings to mind a conversation I overheard recently about a woman who is a known drug abuser. She is a very poor "attender" at both her hospital and GP midwife ante-natal clinic and her own midwife was on holiday and a message had been left asking for the group to follow up the fact that the woman had defaulted her hospital clinic appointment. I overheard one of my colleagues saying "Why should we do all the running around after these women. It is their responsibility, if she can't be bothered to come, why should we spend time looking for her?" Whereas I would think, "This woman has particular needs which are not addressed by the institutionalised way that the service is offered and we have a responsibility to her and also to her baby to try to provide care that matches her needs".'* (Veronica, lecturer-practitioner)

An educator, was one of the few interviewees who included herself when she spoke of pre-set attitudes and assumptions that can prevent midwives from fully assessing a woman's needs:

> *'Certainly our attitudes can display inequalities of health care and often inequalities are based on assumptions and stereotyping ... Sometimes inequalities aren't just about not providing the right service for that particular woman, it is about perhaps not even finding out what she wants in the first place. So maybe you are likely to provide inequality for those who are least like us. So you might assume that something is right for somebody but they don't fully perhaps understand their background or their needs or their own personal beliefs ... So that is lack of information.'*
> (Shirley, educator)

Here, unequal provision is directly linked to lack of familiarity, drawing attention to the need to find out about women before attempting to provide for their needs, an issue that is discussed in more depth in Section 7.3.2.

In practice, midwives probably need to learn how to maintain a careful balance between focusing on the individual and attention to the social and cultural context within which that individual is living and receiving care. This may not be easy for students to grasp, and they can be left feeling unsure about what is actually required of them. This may be particularly acute at the beginning of their education. A first-year student was asked about her understanding of what it means to be disadvantaged:

> *'If you can't do the same as everyone else. Not being "normal" if anyone is normal.'* (Gaynor, student)

When asked who the research project should be looking at, Gaynor was reluctant to specify any particular groups or sets of needs:

> **Gaynor:** *'I don't know. I suppose everyone, to get an idea of how different people are treated. So you would need to look at – I wouldn't say, like ethnic minority groups – it needs to be everyone. I wouldn't want to pick out one certain group … Just all minority groups.'*
>
> **Interviewer:** *'Who do you see as a minority group?'*
>
> G: *'I don't know really. I suppose that is what I mean by "all", because everyone falls into different groups don't they. So that's why I didn't want to pinpoint one certain group of people to say they are anything different.'*
>
> I: *'That's fair enough. So you want to avoid putting that?'*
>
> G: *'Yes. I suppose random, but then you won't be including everyone.'*

A student approaching the end of her programme, spoke of direct forms of discrimination being embedded in the way in which health care providers relate to their clients. She made the following comment in response to questions about unequal provision:

> *'I think it is affected by health care professionals as much as it is affected by funding and economics. I think, looking at institutionalised racism, if you have got people who are racist, whether it be consciously or unconsciously, then it is very difficult to provide an equal service.'*
> (Catherine, student)

Most respondents in Case Site A who mentioned the potential role of health professionals in exacerbating inequalities in health did not mention their own practice. Even Shirley, who seemed to some extent to be speaking about her own practice, on the whole used terms such as 'you' and 'they' rather than 'we' or 'I'. Although reflecting on one's own work is an important part of the role of health professionals and has been given much attention in the literature, the difficulties involved in such reflection have not been as widely debated (Brechin et al., 2000).

### 6.3.2 Knowledge, skills and attitudes needed for midwives to promote equality of care

From analysis of the interviews of managers, midwives, lecturers and students, we were able to extract some of the types of knowledge, skills and attitudes that appeared to be needed by midwives if they were to promote equality of care. In most cases, views seemed to concur, broadly, with the views of the women they cared for, although, as the women's accounts suggest, such knowledge, skills and abilities were not always in evidence. The knowledge, skills and attitudes mentioned by respondents can be categorised into three main areas:

- knowledge about the social/cultural context of women's lives
- understanding the nature and boundaries of the midwife's role
- attitudes and communication.

#### 6.3.2.1 Knowledge about the social/cultural context of women's lives

Writing about caring for women in poverty, Salmon and Powell (1998) emphasise the importance of midwives understanding the broader context of women's lives in order to deliver effective care. This was echoed throughout the interviews with midwives, students and lecturers. Clarissa, a community midwife, spoke of the need to understand the challenges facing her clients, to know what their lives were really like. She thought that home visits were the best means to acquire this knowledge. The following story was recounted on several occasions by one of the educators:

> *'One student went to a house and was asked what would she like to drink and she wanted a blackcurrant tea and clearly it was not a household that*

99.

> *stocked blackcurrant tea. I don't think I have either! So I think the midwife pointed out to her that she should have just asked what they had got and then have whatever, or not have anything at all. And then the next day the woman had actually gone out and got blackcurrant tea and she could ill afford special teas.'* (Felicity, lecturer-practitioner)

A community midwife also spoke of the importance, for the students' experience, of seeing women in their own home environment:

> *'... I think the students who come out to our area would certainly be wise to the fact of what happens and the real situations that they go home to, these people. And I think it is very important for them because sometimes on delivery suite you go into the same room as everybody else who is having a baby and the delivery suite looks the same, you get the exact same care. It's very different from what these people are used to in their own set-up, I think. And also when you work in the hospital, you can forget there is a huge environment out there. Because you're a hospital midwife it's not really your responsibility to actually think too much beyond what's happening in bed 4. Has she fed, water, passed urine or whatever else.'* (Jean, community midwife)

This view of hospital midwives taking a functional, rather than holistic approach to care arose in all three case sites and was regularly endorsed by other midwives and service users. Service users repeatedly felt that midwifery care in the hospital context fell short of that in the community. For example:

> *'... not all of the hospital midwives I mean, but the community ones are more caring. It seems that the community midwives take more time out because when you're in hospital it's all just run of the mill type of thing. It's just "do this, do that". There were a few who would stand and talk to you but then it just seems that there's a complete difference between the two.'* (Tania, service user)

This issue is discussed further in the analysis of Case Site B.

A community midwife, felt that hospital midwives were not necessarily required to understand the social circumstances of women's lives, but stressed that such an understanding was necessary for her to deliver care appropriate to individual needs. She spoke about Hattie, a young mother of three. Despite facing what seem like enormous difficulties, including her own learning difficulties and bringing up her three children and her younger sister in a two-bedroom flat, Hattie asked for very little from her:

> *'Mainly [Hattie] wants to be reassured that the baby is healthy because she does look after her children and she does very well. If you saw her first and didn't know anything else around her, as in a picture, you would think she is a very capable young girl. She could probably come to me with loads of woes and money problems and then support her mother and partner, that's there sometimes. But she just wants to know that her baby is growing and everything is fine and to be reassured.'* (Jean, community midwife)

However, Jean made her own assessment of Hattie's needs and felt that home visits were important for someone in Hattie's circumstances:

> *'She didn't actually cry for assistance, but little things like she thought she was in early labour last week, she doesn't have any transport and I said "I can drop round to see you". Now that was brilliant for her. Rather than get somebody to collect the kids from school, bring the baby, who must be about 18 months, she would have had to bring him up here with her.*

*I said "I'll just pop round to see you", and she wasn't [in labour]. She was just having niggles, she just needed reassurance and little things like that. I knew her social circumstances and when she phoned me … But you can't write all these social circumstances up and say to somebody if she calls please try and go to her rather than her come to you, because it is just so awkward. But she is appreciative.'* (Jean, community midwife)

This account is interesting as it appears that Jean's ability to understand and empathise with Hattie was crucial in enabling her to deliver the appropriate care; in this case, a home visit. The appropriateness of the care is borne out later in an interview with Hattie. Despite answering *'you shouldn't expect nothing'* when asked about her midwifery care needs, Hattie clearly did have strong views about what her needs were and what she disliked. For instance, she clearly expressed a preference for continuity of carer, and found having her care shared between her own GP and one midwife as *'nice; better than being shoved from one midwife to the next'*.

However, Jean's referral to her client as 'appreciative' is also worthy of comment. One wonders whether a service user who was not appreciative would have been given a home visit. This incident is a possible example of the manner in which some health professionals may implicitly perceive their work as 'charity work'. The ideological nature of the concept of care in this regard has been raised in the literature (Brechin et al., 2000).

Whichever interpretation of Jean's attitudes and behaviours is applied in this situation, it was clear that Hattie felt that Jean was able to relate to her well. She described another midwife as fussing around her, and being snobby, although she acknowledged that this may have been a personality clash. How to enable health professionals to relate to service users in a way that does not alienate them is a complex issue and has been the subject of much debate (Cunningham and Henggeler, 1991; Hart, 1997).

#### 6.3.2.2 Understanding the nature and boundaries of the midwife's role

Much of the work midwives do to support women who may be disadvantaged or experience inequalities in health care provision involves giving practical support, often only indirectly related to pregnancy and birth. Analysis of the data from this case site suggests that interviewees felt that the work of a midwife therefore involves being clear about the nature of the midwife's role, about what practical support the midwife can give and when to refer on to other professionals. This section therefore addresses three interrelated issues: the midwife's role with regard to inequalities, the limits of, or boundaries to, that role and the importance of multiprofessional team working.

Midwives, students and lecturers were all asked whether they thought midwives had responsibilities with respect to inequalities in health and health care provision. There was general agreement that midwives did have such a role and many examples were given of care that attempted to fulfil this role. There were few examples of midwives working in identifiable specialist roles caring for specific disadvantaged service users, although some worked primarily within areas in which most clients were socio-economically and educationally disadvantaged. There was, however, a support and education group specifically for younger parents, which was the result of a particular midwife's interest in and commitment to this client group. However, she developed this role herself and it was not formalised within the institution.

The issue of specialist versus more generic roles is debated in relation to many caring professions and client groups (Hart, 1995a). Debates centre around the degree to which such work has the potential to further stigmatise service users, or whether such roles enable practitioners to meet complex and specific needs more effectively. Despite the existence of a 'specialist' midwife for younger mothers, there is no evidence to suggest that the provision of specialist support to other client groups was being debated at this case site. There appeared to be no clear strategy concerning the issue of specialist support; rather it seemed that midwives were left to develop their roles according to their own interests. Thus, if specialist provision was not provided, it may have been the case that certain client needs were not being met because there was no midwife with a specific interest in that area. This has implications for midwifery education, since there is clearly a need to make students aware of the different ways in which specific service users may be targeted, and their relative effectiveness.

Despite the relative lack of specialist provision, most respondents perceived a need to address inequalities. Some had clear ideas about the midwife's role in helping women access the service. Felicity, the lecturer-practitioner who ran a teenagers' group, spoke of her role in relation to this particular group:

> *'... there are some people who are better at getting things than others and that is one of the things that I think the teenage group teaches the teenagers, is how to access all sorts of services. They quickly learn to do it. If you are just there and they know to drop in and say "How do I get such and such?" and you either point them in the right direction or take them, or whatever they need, they quickly learn to do it for themselves.'*
> (Felicity, lecturer-practitioner)

A community midwife also spoke of the midwife's role in assisting those who did not know how to access the service fully:

> *'... makes me think of people who don't speak English well and don't get what they're entitled to, as they don't know how to ask for it, and also a social class issue. Middle class people will ask and get, what they want and people who aren't as articulate, or don't know what's available, don't get the same sort of service. We should be trying to do something about it. It makes me want to spend more time with people who don't know how to ask for things.'* (Clarissa, community midwife)

Thus she had no doubts that midwives have a role in relation to tackling inequalities:

> *'I suppose we should be working in a more organised way to try and change things as well as make a difference individually. Good example, very little literature in Urdu, we should perhaps be making a bit more fuss about it. The Sure Start programme that's just begun in [one area of city] and [another area of city], we wondered if we would be able to get some money from that to do some local translating of leaflets.'*
> (Clarissa, community midwife)

When asked about how she supports one of her clients, whom she described as *'an Asian woman who had recently moved from London'*, Clarissa, responded:

> *'A lot of it [is] being one person to refer to about her pregnancy and any anxieties about that; knowing how to get in touch with me apart from coming to the clinic. Telling her a bit about what's available at the hospital and what it's like compared with the one in London, providing good physical ante-natal surveillance. I also arranged an interpreter to come for her scan; she had to have a detailed cardiac scan because of previous [obstetric history].'* (Clarissa, community midwife)

Another community midwife, was also in no doubt about her responsibility with regard to inequalities. She spoke about the importance of the clinic appointments as a time to build up trust with women before they will confide in midwives about their situations and needs. She also expressed some frustration that her role in this regard was not always fully understood by some of her colleagues:

> *'... sometimes people will say "It is very easy to do Jean's clinic. It doesn't take very long." Well, it takes as long as you put into it. Like, if you know the women and they get to trust you, of course they are going to start*

> *saying things to you in your 20 minute appointment or whatever. Whereas if somebody else does my appointments, they tick the boxes and whatever else. So I think it's probably what you take on board.'*
>
> (Jean, community midwife)

A lecturer-practitioner who worked half time on the community, was also clear about her responsibility with respect to inequalities; housing issues seemed to be prominent:

> *'I think we have a social duty. I am always writing to social services, the council, housing department to say Mrs Bloggs lives on the third floor. She is pregnant, has got two young children and could she be re-housed.'*
>
> (Felicity, lecturer-practitioner)

A community midwife commented that not all midwives felt the same level of responsibility for tackling inequalities, and felt some did not take account of cultural differences:

> *'I think [commitment to inequalities amongst my colleagues] definitely varies. I think I have changed hugely now because I have got more close to my own caseload, but I don't think you can have a true appreciation of what they are going home to or what they are used to until you have seen how they live, their own network. I remember people saying, "Oh [that lady's] family have brought in her tea and you can smell it down the corridor". Well, she doesn't see that as a problem. Everybody else on the three-bedded ward will, and the midwife is saying "It stinks".'*
>
> (Jean, community midwife)

While critical of her colleagues, Jean clearly understood their frustration. Taking responsibility for the delivery of equality of care necessarily carries some frustrations and demands a good deal of patience, understanding and empathy. In a discussion which began with the question 'Do you feel a sense of responsibility amongst your colleagues?', the following exchange occurred:

> **Interviewer [note the leading question]:** *'Do you feel frustrated with any other colleagues, medics or midwives sometimes?'*
>
> **Jean:** *'Yes. But I can see where their frustrations come from. And I am sure we could all fall into that category at some stage because it is so difficult to communicate and then [the service user] will say "I only want to see a female" and there is only a male anaesthetist and a male doctor, and you think "Oh no". But it's their culture, it's not something you can say "Listen, he's a really nice doctor". It may be a really nice man, but it's still a man. And if her husband is not allowed into the delivery suite, how on earth can we ask a man to come in and do an episiotomy and a ventouse … I've done lots of courses about ethnic minorities in my own time, sociology courses and stuff and you know … where they have all come from and their own cultural background. They may be born and bred in this country and were educated here, but still, if their husband has just come from Pakistan he is still very entrenched in their ideas, and they are not going to change.'*

A lecturer-practitioner expressed similar frustrations, this time about her colleagues' lack of appreciation of social disadvantage:

> *'I think some people are very much more aware than others. I can remember being at a social event with one of the community midwives. I was really shocked when she said "There is no social deprivation in [this county]" and I thought only the day before a midwife had been telling me about a family in a deprived part of [the city]. Where the toddler was*

> *begging for a Weetabix at 11 o'clock in the morning because that was all that there was in the house to eat, a dry Weetabix, and she was hungry. And yet a few miles away there is this total unawareness that some people live in that way.'* (Veronica, lecturer-practitioner)

The lecturers also spoke of their responsibility with regard to inequalities in health care and, in contrast to the practising midwives, their comments related to their roles in challenging assumptions and attitudes that might lead to the provision of unequal care. Both students and midwives were mentioned in this context. Shirley was asked whether she considered that educationalists like herself had a professional responsibility with regard to tackling inequalities in health provision:

> *'Yes, definitely. I have definitely got the job of challenging attitudes and that might be students and obviously that is the greatest impact. I think in terms of midwives as well, we have got a remit: our involvement with staff development and continuing education. And you do get quite a lot of feedback with things like the students work, particularly the practice based learning contracts that we use and things that they say about practice, we can interpret, and you get quite a lot of feedback about attitudes. And there are ways in which we can feed back that, perhaps not blatantly, that's too challenging, but through mental preparation.'* (Shirley, educator)

One of Shirley's classroom sessions was observed, which explored attitudes towards parenting. Shirley clearly tried to move students beyond traditional concepts of the family, drawing attention to lesbian, teenage and single-parent families. She showed two overheads quoting literature which challenged assumptions about lesbian parents:

> *'Recent evidence has failed to demonstrate that gay or lesbian parents are any less fit to parent than their heterosexual counterparts.'* (Laird, 1993)

> *'Children of gay parents are vicarious victims of rampant homophobia and institutionalised heterosexism.'* (Stacey, 1996)

Shirley invited students to comment on the overheads. However, even in this small group context students, who were often vocal and participatory, did not comment. Rather than teasing out the reasons for their silence, the lecturer then went on herself:

> *'I don't think it's totally accepted. Prejudice is a very difficult thing to illuminate. The official message does not necessarily permeate society.'* (Shirley, educator)

Shirley's reasons for not challenging the students' silence may have been connected to the reservations she expressed above about addressing student attitudes through direct challenges, which may be too threatening. This concurs with Miller et al.'s (1994) observations which suggested that teachers were concerned about getting into deep personal issues without the skills to deal with them. Students were more forthcoming in discussion about single parenting, teenage parenting and parents with disabilities, suggesting that these issues were less threatening to them. The issue of attitudes towards lesbian parenting is further explored in Case Site C.

Shirley was also asked if she thought that practising midwives had a similar responsibility in working towards equality of care. She agreed that they did but thought that their limited time for reflection could inhibit their role in this regard:

> *'I think they do, but I think it's harder in a way for practising midwives, because they don't have the opportunity that students have to even discuss things in groups. They don't have the time to sit down and talk things through. I also think that by the time you are qualified you are a little bit more set in your thinking perhaps. There aren't the opportunities to*

> *change that, so you should change that at an early stage with students before they become a bit more set in their ways.'* (Shirley, educator)

Another educator also thought that she had a professional responsibility with regard to addressing inequalities in health and health care. For her, equalities in health care provision were best provided via the implementation of the philosophy of individualised care, which was embedded in the institution's curricula philosophy statements. She saw her responsibility as being about ensuring that individualised care was provided to all women and this meant helping students to be able to assess individual needs and avoid assumptions based on the stereotyping of particular groups:

> *'In one word, it is individualised care again. In several words it's things like helping students to examine stereotypes, helping them to look at attitudes, helping them to become self-aware, helping them to look at roles and it is as much that as teaching them that "Muslims do this and Jews do that". Yes, we do that but it is usually prefaced by "Hang on a second, you can't guarantee that, we are talking in very general terms and not everybody may conform to any of this."'* (Saskia, educator)

Students also talked about their responsibilities with respect to inequalities in health care provision. Lara, nearing the end of her pre-registration education, saw her responsibility as making sure that all women were aware of what is available to them, and as a consequence:

> *'... if I felt that they were less likely to use or take up those opportunities, I might encourage those women who I thought were less likely to, actively encourage, if you know what I mean. Say, like a teenage mum, and I was trying to encourage her to go to the young mum's club but I thought maybe she was a bit shy or whatever. I might find some kind of way of letting her realise that it wasn't intimidating, or maybe introduce her to another girl in the same situation, or something like that.'* (Lara, student)

Nicola, also nearing the end of her programme, agreed that all midwives, including students, have responsibility with regard to inequalities, but recognised that this can often feel overwhelming, both to students and qualified midwives:

> *'... sometimes you get so overwhelmed by the enormous task of it, that a lot of midwives just give up and think "I haven't got the energy any more". I think we can, like students who are newly qualified, I think you are quite idealistic and you can see the other midwives certainly going "Yes. Right. You wait, give it a few years and you will be completely demoralised and much the same as everyone else." But, yes, I think you do have a responsibility for it and it must come across in your ethos even if you can't do that much different. But your attitude towards people and the fact that you take the time and are aware that there are inequalities, as opposed to being defensive. I think quite a lot of people are quite defensive in their practice. But you can understand how ... because they are just exhausted and underpaid.'* (Nicola, student)

Thus, despite most respondents' obvious concern for the need to address issues of inequality, it was clear that some felt this had limits. A midwifery manager, agreed that midwives have a role here, as did other health professionals but was quick to point to its limits:

> *'I think it is not just individual midwives; I think they can do their bit. And I suppose it is not "midwives"; it is us as a multi-disciplinary maternity services really. And not just the maternity services, but as a health service. You know, if you take an even greater step back, you know, GPs etc. have to be involved as well. But yes we do have a responsibility*

> *and individual midwives, with their knowledge of the issues for child bearing women, also have a responsibility to feed into the debate.'* (Sue, midwifery manager)

Veronica, a lecturer-practitioner working in the community, was clear that she had responsibilities for tackling inequalities but, for her, the question of power to change situations was paramount. She felt that midwives had limited power to implement change. Her perspective raises the question about the limits of the midwife's role with respect to inequalities, a point echoed by other respondents.

A community midwife also had a clear understanding of the limits of her own role. Whilst she assisted women in benefit applications, she felt that she could not be expected to keep up with benefit regulations and entitlements. Her responsibility, she argued, was to point women in the right direction, although she did not explore what should happen if women found it difficult to access such services due to language difficulties and/or learning difficulties:

> *'These are things that change every few months really and the conclusion you come to is that you need to send people off to the actual agency to deal with it. What I need to know is where is the housing agency, how do people put themselves on the council list, how do they complain about sub-standard housing, where do they get their milk tokens, how do they find out if they're entitled to sickness benefit, all those sorts of things. So you need to know where to direct them in the area.'* (Clarissa, community midwife)

However, Clarissa also exhibited frustrations with the limits to her role at times. Talking about a first-time young mother living in overcrowded housing, she described her role in her care as:

> *'Making sure we get the benefits that she's entitled to in the material sense. Trying to help her think about what it's like to be a mother, but I wouldn't say I get very far with it really. I wasn't able to persuade her to attend any sort of parentcraft, even though I offered various choices. The problem is the one up at the hospital for young mothers is two bus rides so it's a big effort. They can get the money back but it's a big effort … I offer the ones at [area of city], which are local and in the evening. Sometimes they do come.'* (Clarissa, community midwife)

This issue, of the limits to the midwife's role arose across the case sites, and further discussions can be found later in the report. Linked to this issue is a need to understand when and how to work closely with other professionals.

The ability to work well with other health and social care professionals is clearly important in the context of delivering equality of care in midwifery. Community midwives, in particular, talked about the importance of good working relationships with health visitors and social workers who were also working with the same clients. A community midwife spoke of her relationships with other professionals, much of which involved liaising about the practical support and advice needed by individual women. She, too, was aware of the limits of the midwife role in these situations:

> *'I do help the ones I feel need helping. And I get other people involved: health visitors and social workers. I work very closely with health visitors. They like to know who is pregnant. And the school nurse fills me in often on the background of all the families.'* (Jackie, community midwife)

However, there are times when the limits of the midwife's role are less clear, and conflicting demands can cause difficulties for individual midwives. Felicity, a lecturer-practitioner, talked about the positive aspects of having a good relationship with the health visitor and GPs attached to her caseload. However, she pointed out that, in more formal child protection cases, multiprofessional working can be difficult as each professional has a different role and relationship to the client. In the context of being asked to provide input into child protection meetings, Felicity spoke of tension between her supportive role as educator and supporter in her teenage mums' group, and the role required of her by social services who are responsible for child protection:

> '... *It is quite tricky for the midwife/client relationship to have to say things in front of the client and everybody about whether you think she is going to be suitable as a mother ... That system isn't quite as effective as you would like it to be, because immediately you are seen as the "us and them" situation. And for the young mums, at the drop-in, I don't really want them being told that they have got to come, and social workers checking up to see that they have been, because that is not the culture of my group ... And also I don't really want to know some of the things that are revealed because it makes your relationship with the client difficult ... And I am better off if I don't know and I take them on face value and I don't make judgements. Because there is an awful lot of their past that comes with them, that isn't relevant now because of what the circumstances were at that time, presumably. So sometimes I think I wish I didn't know that. I also feel uncomfortable that they now know that I know that.'* (Felicity, lecturer-practitioner)

Felicity was aware that many women do not feel comfortable with health visitors, whom they perceive to be judgemental, and that by taking part in child protection case conferences, she may be seen in the same light. She said that she found it uncomfortable to take part in and to provide written evidence for child protection conferences:

> '... *But the relationship is different with the health visitor and it is very apparent that some of the girls don't like the health visitors going round because they feel that they are criticising them or judging them or whatever, whereas midwives, hopefully, they see them in a different way.'*
> (Felicity, lecturer-practitioner)

Felicity's concerns are borne out by research evidence which highlights how health visitors are often perceived by service users as surveilling them and how that perception hinders their care (Bloor and McIntosh, 1990). In the present study several women were found to be unhappy with their health visitors, whom they perceived as being interfering or patronising. These women often had easier relationships with their midwives.

Lily, an 18-year-old mother who had just had her first baby, was interviewed with her mother Annie. Both Lily and Annie talked about Lily's midwife, Clarissa, and the health visitor; both had experienced Clarissa as supportive and inclusive in her approach to Lily's care. Lily was asked who, amongst the health professionals she came into contact with, she found to be most important to her:

> **Lily:** *'My midwife.'*
>
> **Interviewer:** *'Can you tell me why?'*
>
> **L:** *'Because when I went down there [for a scan] she can tell you where the head is. And I had my scan, they said at the bottom of his back was a gap and it began with an "h" and I couldn't pronounce it. Nor could the midwife and so she wrote it down and she followed it up and she said it was nothing to worry about.'*
>
> **I:** *'She was the most important, any other reason why she was? Anything else she did that made you quite impressed?'*
>
> **L:** *'Mum says she felt confidence in her.'*

> **Annie:** *'She really included me too, you know. She didn't just ignore me 'cause I wasn't the husband or anything. She says, "right then" and told me everything too. I felt really included.'*
>
> I: *'Anything else that you thought was good? We are trying to think what it is about a midwife that makes them good or helpful to people?'*
>
> A: *'When she came to give [the baby] his jab she really explained it to us didn't she?'*
>
> L: *'Before she did it, she was talking about it, what she had to do and that.'*
>
> A: *'She was talking Lily through it, 'cause she could tell she was a bit worried about it.'*
>
> Lily was also asked about her relationship with the health visitor:
>
> L: *'She's one of these persons who thinks she knows it all but she hasn't got no kids of her own.'*
>
> A: *'She just comes round sticking her nose in and she's got no kids of her own. She thinks she's better than us, but I've had loads of kids and I know what I'm doing. She doesn't.'*

Both Lily and her mother Annie experienced the health visitor's approach as interfering. For them the midwife's approach to care worked well. They felt that she explained everything clearly and, importantly for both of them, she accepted and respected Lily's mother's role during the pregnancy and birth. Overall, a relationship of trust and confidence was built up. This contrasts strongly with the approach taken by the health visitor, which they perceived as being overpowering and patronising, leaving them feeling excluded. Lily was asked what she thought the most important things health professionals or social workers needed to for someone in her situation. Her response was unequivocal and was supported by her mother: *'Not be a know it all'.*

This discussion points to the importance of health professionals having good communications skills, an issue that is covered in more depth in the following section.

### 6.3.2.3 Attitudes and communication

Communications skills, especially listening, were mentioned on many occasions by midwives and lecturers as key midwifery skills. Clarissa, a community midwife, thought that 'listening sympathetically' could make a big difference to women, most of whom realise there is little midwives can actually do about their circumstances. A midwifery manager also spoke of self-knowledge and communications skills, when asked what she looked for when recruiting staff and students:

> *'It's having people who are self-aware of how their own personal life experiences affect what they are today … you need to be fairly self-aware to be able to address effectively the needs of women, couples, families at that time. It's a vast area, this question. Communication skills are a big thing. You need to have good communication skills before you start, if that's not happening it needs to be addressed. You can be brilliant clinically and in making decisions but if you haven't got communication skills, one needs to question whether you're the right person for the job. With communication skills comes the ability to listen to people, to give them general choices, explain things and treat them as equals; sharing information and helping them make decisions that are right for them.'* (Melanie, midwifery manager)

An important aspect of good communication seemed to be 'the right attitude', which most respondents described as a 'non-judgemental attitude'. This was mentioned by both providers and recipients of care. Felicity, lecturer-practitioner, spoke of the importance of being aware that people who live in particular areas may have particular needs, whilst avoiding making assumptions or value judgements. A community midwife said that all students were taught to be non-judgemental but implied that this did not always prepare them to meet practical difficulties:

> *'They all learn about being non-judgemental [but] when they are faced with a woman who doesn't speak much English, they are pretty well floored. A lot of them don't know how to try, they lose touch with the fact that just smiling at someone makes a big difference.'* (Clarissa, community midwife)

Whilst having a non-judgemental attitude was deemed imperative by almost all midwives and students, several accounts were given of cases where midwives thought their colleagues were judgemental in their attitudes. A lecturer-practitioner, spoke of attitudes amongst her colleagues toward women who abused drugs:

> *'The attitudes and assumptions are often based on the lack of actual information. Attitudes to women whose health behaviours are not perhaps what we view as good for them, like people who abuse hard drugs. People are very judgemental in how they talk about such women and don't always recognise the physiological addiction aspects of what is going on. They assign fault without having a real understanding of that individual's circumstances.'* (Veronica, lecturer-practitioner)

Veronica thought that education had an important role here and that her role as a lecturer-practitioner was particularly helpful in enabling her to tackle such attitudes:

> *'I think it is useful being in practice with what you have access to. Like the example of the midwife talking about the drug abuser and why should we bother. That is useful case material for discussing in the classroom, and [asking] "What would your views be about this situation?"'*
> (Veronica, lecturer-practitioner)

Students were aware that they were expected to be non-judgemental but did not always feel that they were given enough support in this. At times, they experienced extremely judgemental attitudes amongst midwives and were at a loss as to what to do:

> *'I think everyone is opinionated and it happens all the time in practice. People are just judgemental, aren't they? Even when you are on delivery suite and you hand over and people say, "There is a really nice lady in there."'*
> (Lara, student)

It is interesting in the accounts above that the difficulties of maintaining a non-judgemental attitude are acknowledged via tales of colleagues' judgements rather than reflections on respondents' own difficulties or limitations. This may be in part due to the way in which questions were framed. However, it may be that participants had some general difficulties in consciously reflecting on themselves. This is interesting given the claims in each of the case sites that reflection is embedded in the programme.

Although the issue of self-reflection was raised in interviews, it was difficult to probe participants to critically reflect on their own beliefs, values and attitudes. It may be that a one-off research interview inhibits the extent to which participants will critically reflect on their own values, attitudes and beliefs. The interviewers were more successful in capturing unwittingly discriminatory comments. For example, some midwives referred to married heterosexual couples as 'nice, normal families' and to certain ethnic minority men as being more prone to violence than Caucasian men. This issue is explored in greater depth in Section 7.3.3.4.

109

Accounts from recipients of midwifery care seem to support many of the views expressed by the professionals. There was general agreement that women needed someone who would listen, not judge, and who could provide support and information appropriate to their needs. The following extracts are taken from women interviewed about their expectations and needs in relation to midwifery care.

Tania had three sons, aged five-and-a-half, two and 12 weeks. She suffered with pre-eclampsia and severe depression with all her pregnancies and her care included hospitalisation under a consultant psychologist, where she was given 'shock treatment' and various medications before the depression was brought under control. She spoke first about the poor communication between different health professionals in the hospital, emphasising the importance of good multiprofessional teamwork. Tania spoke about her relationship with the community midwife, and stressed the importance of having someone who could listen and understand:

> *'... She was always asking about the depression, she remembered from before. I remembered with [second child] I got really upset and she had her arms around me, she was like my mum. She knew what I went through before and she kept on saying to me "I'm here if you need me". Because she was discharging me and she said I could ring her if I needed her.'*
> (Tania, service user)

Although Tania was clearly satisfied by her community midwifery care, when asked what she thought would make a good midwife for someone like herself she said that midwives should know more about post-natal depression. It may have been that the midwives caring for her had not received training or recent updates; however, the student cohort in the study received a session from a consultant psychiatrist specialising in post-natal issues. This session was observed to be highly informative.

For someone like Tania, with a complex set of problems and needs, continuity of care and carer seems particularly important. Such continuity was best provided by the community midwives who could see her in her own home. One of the problems that Tania experienced in hospital was feeling as if she was being told the same thing over and over again by different professionals, as well as being treated as though she were a first-time mother. Tania's experience supports the point about the need for good communications skills. In particular, it suggests that her carers needed to be able to check with her what she already knew and understood about her situation and care before going through it again each time.

Hattie, a mother of three, had her first child at 15; her children were now aged six, three, and six weeks. She spoke of her experience of being a 'young mum' and how she often felt judged by health professionals. She was asked what more could be done in midwifery education to ensure that midwives met the needs of women like her:

> *'I don't know really, I'm no good with ... you see my opinion is different to every other opinion but as a young person, I think not to be judged really, but you shouldn't judge a book by its cover. I'm more mature than what people think I am but that's only because of what I've gone through to be mature. Some people treat you as though you are thick but you're not. I suppose they do that wherever you go, if you look like a certain person they think don't give her this. I don't know it's all a load of bullshit really, one rule for one, one rule for another. I suppose if I was older I wouldn't have been judged as much as being younger. People think I'm older than what I am.'* (Hattie, service user)

This section has explored knowledge, skills and attitudes participants perceived midwives to need in order to deliver appropriate care to disadvantaged service users. In particular, the need for in-depth knowledge of a woman's cultural and social circumstances, a clear sense of the midwife's role in relation to such client care, as well as well as good communication skills and appropriate attitudes were raised. The following section discusses the educational context.

### 6.3.3 Midwifery education: inequalities and the delivery of equality of care

The research sought to investigate where student midwives learned about inequalities issues, what they learned and, in particular, the relative importance of theory and practice and the links between the two. In this context, the following issues arose and will be addressed in turn:

- teaching and learning about inequalities
- theory-practice links
- the importance of practice placements
- the importance of reflection
- the assessment of understanding of inequalities issues.

#### 6.3.3.1 Teaching and learning about inequalities

The curriculum analysis suggested that almost half of the modules on the pre-registration programme were concerned either directly or indirectly with inequalities. Thus there is evidence that such issues were to some extent permeated throughout the programme. In contrast, students tended to point to one of two modules where inequalities were explicit when asked where they learnt about inequalities. The Year 1 sociology module and the Year 3 module on 'special needs' were both mentioned frequently. Amongst students, a range of views were expressed about the sociology module, from positive to negative. A student nearing the end of her programme was very positive about its value and placing. When asked about inequalities in health, she mentioned this module immediately:

> *'That makes me think of my sociology module, about the fact that there are differences in health between different social classes, between different ethnic groups, between gender.'* (Catherine, student)

For Catherine, this module had introduced her to issues which she built on in later work, including her dissertation:

> *'I found it quite useful because of what I am doing for my dissertation. Last term I actually looked at the special needs of ethnic minority women and some of the things you need to take into consideration and you need to be thinking about, and so I drew on it quite heavily.'* (Catherine, student)

A student in the middle of her programme felt similarly, although she saw its value only in hindsight: *'looking back, [it] is now coming in handy'.* She continued:

> *'The first-year module is taught by a sociology tutor at [the university]. It's a mixed class with other health professional students. It teaches you about social factors which influence health. This has been really helpful. I realised how you can be judgemental. You have to keep in the back of your mind what's going on for her. You don't have the knee-jerk reaction that you would have if you hadn't done this module.'* (Annie, student)

However, Nicola felt very differently and her views were echoed by others. When asked to reflect on what she had covered in relation to inequalities in health in her three-year programme, she responded:

> *'In my first year we did lots of sociology stuff, we did lots of that kind of thing. But most people perceived it as a waste of time, because they had come to be midwives and perhaps we would be better doing it now we*

> *have practice to relate to it. But when you have not got any practice, especially if you have come straight from school, I don't think you have many examples to relate to it.'* (Nicola, student)

It seems that for students there were two main problems with the placing of this module in Year 1. First, they had had no practice experience and therefore were unable to make sense of the theoretical issues, making the module seem less relevant than it might otherwise have. This reflects the argument against the 'front-loading of theory' model made by Eraut et al. (1995) and Fraser et al. (1998). The second problem was that it was shared with other health professionals and was not applied specifically to midwifery, which caused some students to question its value. Concerns of this nature were expressed in Kent et al.'s (1994) evaluation of pre-registration midwifery programmes. One further problem, raised by Veronica, a lecturer-practitioner, was that the concepts introduced in this module might be too difficult for some students to grasp at that stage of their studies.

The second module mentioned in relation to inequalities in health was the third-year 'special needs in midwifery' module (since re-named due to debates around the concept of special needs). Again, there were differences of opinion about its value and significance for learning about inequalities. As student cohort representative, Catherine had canvassed other students' views. She felt that most liked the fact that this module was specific to midwifery:

> *'... everybody was saying "We should have done this earlier" and I think they are trying to address that now. Because basically the first two-and-a-half years we didn't do anything specific to midwifery and you need to incorporate the two.'* (Catherine, student)

On reading a draft of this chapter Felicity, an educator, suggested that we emphasise that this view was factually incorrect. In the four-year programme to which Catherine refers, midwifery-specific modules began 18 months into the programme.

However, Catherine felt that there were problems with the way in which this module addressed inequalities issues:

> *'I think it does what we try to avoid doing. It singles groups of women out, or individual women out, and says that they are different and special, which they are, but it should be incorporated into everyday practice. It shouldn't be something out of the ordinary and I think this module very much made it like this; a peculiarity which I don't think it should be.'*
> (Catherine, student)

During one classroom session observed, a practising midwife was an invited speaker, and expressed a similar opinion to Catherine's. She felt that it was too easy to overlook the individual woman when taking a special needs approach. She recounted an incident where, in her opinion, a woman had been treated as *'a schizophrenic having a baby'* rather than as *'a woman having a baby'*. The midwife had apparently talked over the woman's head, used inappropriate language and abbreviations that she would not have used for other women. Her point was well received by one student, who cited work by Schott and Henley (1996) and argued that a problem with addressing women's special needs was that it placed too much emphasis on difference and one can forget the fact that women still have an enormous amount in common.

From the classroom observations it was clear that inequalities issues arose in classes which were not explicitly focusing on such areas. Thus the data add credence to the claims made by some participants that issues of inequality were well integrated into the programmes. However, the precise manner in which this was achieved is worthy of analysis, as different educators had very different ways of framing inequalities issues.

For example, in one session, a consultant geneticist who was teaching ante-natal screening used slides to illustrate 'syndromes', 'defects' and 'abnormalities'. The consultant put up a slide of a cleft palate and the following interchange occurred:

> **Consultant:** *'Cleft palate is horrid and we try to pick it up. Has anyone seen one?'*
>
> **Student:** *[Hesitant] 'Actually I was born with one.'*

It is shocking that the consultant made no attempt to engage with this student's comments, or to apologise for her insensitivity. This demonstrated a complete lack of self-awareness on the part of the consultant which was all the more disturbing given that the consultant 'counsels' women in relation to 'foetal abnormality'. In a more sensitively delivered class, the student's experience could have precipitated a debate concerning the ethics of screening for abnormalities, and how to advise women in a culture which devalues such difference.

Although later on in the session, the consultant mentioned the issue of ethics in relation to people with Down's syndrome having children, questions of ethics, politics and social constructions were largely absent throughout. By the repeated use of terms such as 'nasty slide' in this session, and the almost total lack of positive reference to living with disabilities, it appeared to be taken for granted by the consultant that terminations for 'abnormalities' were to be encouraged.

The session by the consultant was attended by a midwifery lecturer who did not say anything during the class. However, one of the fieldworkers was present when the students next met with this lecturer. At the start of the session, which was on an issue related to the session by the consultant geneticist, the lecturer made reference to the consultant's class, which she had found 'upsetting', and made clear that she felt very differently about these issues. However rather than generating a discussion about ethics in a professionally-informed way, she merely stated:

> *'Ninety per cent of women terminate Down's babies. In other parts of Europe I see more Down's people etc. We don't see it here because we terminate. It's horrible, isn't it.'* (Educator, classroom observation)

It is interesting that the lecturer did not present any counter views during the consultant's session. This may, in part reflect the issue of power hierarchies in the NHS.

An important point here is that, even though inequalities issues may permeate the curriculum, there is often a marked difference in the manner in which different educators incorporate them. These differences depend to some extent on the lecturer's expertise, but also to their level of cultural and social understanding, and their own capacity for reflective practice. As Veronica, an educator, pointed out, lecturers have different levels of awareness of inequalities issues. Other classroom observation data shows that even educators who appeared in other contexts to have a high level of cultural and social awareness display subtly discriminatory attitudes towards, for example, people with disabilities by using such terms as 'retarded' and 'mental handicap', and by stereotyping. Furthermore, there are examples from the data in this case site which show how educators gave students their own, sometimes potentially discriminatory opinions, rather than presenting research evidence and/or contrasting perspectives. This is not belying the importance of lecturers explicitly 'situating themselves' in relation to ethical, social and political debates. However, a greater sense of awareness is needed on the part of educators regarding the ways in which they use their personal perspectives in class. This point raises the fundamental importance of reflective practice in the context of such complex social and political issues. The provision of a forum in which lecturers can reflect openly on their own views and beliefs is of relevance here.

Students within this case site said they found it hard to challenge staff's discriminatory views, although this primarily applied to clinical staff. However, during the feedback session in which the preliminary findings were presented at Case Site A, when this finding was mentioned, both midwives and educators were extremely surprised. The perception was that students openly, and frequently, challenged their views.

Given the findings on some attitudes and values of lecturing staff, it is perhaps unsurprising that some students also appeared to hold openly discriminatory attitudes. Catherine, a student, lamented that she found such views amongst colleagues almost impossible to challenge, a point that is relevant for lecturers when thinking about the challenging and assessment of attitudes amongst students. Lecturers themselves did not raise this as a problematic issue, although some students stated that they did not think their attitudes were challenged by staff. Analysis of classroom observation data from Case Site A corroborates this and reveals few incidences in which lecturers challenged students' views. However, although the observers frequently witnessed students making naïve and stereotyping comments (e.g. conceptualising all people with learning difficulties as having a 'mental age of nine'), no openly discriminatory attitudes were seen being displayed by students.

The difficulties of eliciting, exploring, and moving students on from discriminatory attitudes should not be underestimated. A student thought that more input from service users in the classroom would be a useful way of confronting prejudice, giving the example of prejudice she had experienced against women who were members of the National Childbirth Trust (NCT):

> *'... we should [have more user representatives] really, because there is so much prejudice within maternity. I mean NCT is like ... and "active birth" is a definite swear word in the hospital actually. But yes, you can get quite labelled if you use any of their stuff, but I don't think we have [enough] user representatives. No.'* (Nicola, student)

However, other evidence from this case site suggests that in fact there was much positive interaction and networking between representatives of the midwifery unit and groups such as the NCT and the local Active Birth group.

Although no classes in which users were present in a teaching capacity were observed, there were clear examples of sessions in which a discussion of students' personal experiences (for example the student who identified herself as having cleft palate) could have been beneficial. Also of relevance are the sessions observed in which service providers taught. Whilst these had the potential to enable students to be advised by those directly involved in practice, some speakers lacked teaching skills, came ill-prepared, and revealed prejudicial attitudes to specific client groups. However, one positive example of the incorporation of service providers' views was a session that linked general debates and facts about domestic violence to midwifery practice.

Practical information was given about the process of referral and what women and midwives could expect from support groups, such as Women's Aid, a national organisation providing refuge. The speaker's dual role as a midwife and a Women's Aid refuge worker was clearly beneficial as she knew the current roles as well as limitations of being a practising midwife. This session was also well-evaluated by the students interviewed.

Thus despite the clear reservations discussed above regarding the title and focus of the module relating to 'special needs' in midwifery, students had liked the opportunity the module gave for introducing users' perspectives. In one session an ex-midwife and mother with multiple sclerosis spoke about midwifery in the context of such a disability. This session was mentioned on several occasions as interesting and relevant.

A further positive approach to teaching and learning about inequalities identified in Case Site A was the use of case studies or scenarios, described here by a student nearing the end of her programme:

> Catherine: *'Last term we were given case scenarios to work on in groups, where you had things like one woman had been sexually abused as a*

114

> *child. The woman we had was very isolated. She was a single mother and she was away from her family. So we worked through situations like that and the agencies you can call upon for help, and we had to go away and find all this out and have a look at the voluntary organisations that might be able to help.'*
>
> **Interviewer:** *'Did you find that useful?'*
>
> C: *'Yes. It was because it made you go away, and we all became aware of things that we didn't even know existed and we became aware of things that we thought would be there and weren't.'*
>
> I: *'Can you remember anything?'*
>
> C: *'Our case scenario, the girl had just moved from Ireland. She had no family. She had got this two-year-old son and desperately wanted to deliver at home and there was the big problem, as she had nobody to be with her during her labour. So we were looking for someone … to build up some kind of relationship with her and be there solely for her; but there was the problem of child care and we went everywhere. As a last resort, social services could have come out and taken the child away, which wasn't really very satisfactory and that was something that could really happen. What happened was that you got stages: you got an ante-natal scenario; a labour scenario; and a post-natal scenario. And as it happened she called us out and the vertex was visible as we got through the door, so the little boy was held kicking and screaming by the midwifery tutor while we delivered the baby. But it really did open your eyes about where to go and we found out about, I can't remember what it is called now, there is a directory of agencies, which none of us knew about. So that was good.'*

It seems that particularly successful teaching and learning is that which allows students to make clear links between what happens in classroom settings and what occurs in practice. The following session considers this issue in more depth.

### 6.3.3.2 Theory-practice links

On the whole, in this case site, there were strong links between university and practice environment. The fact that the university department was located in the hospital, across the corridor to the maternity unit undoubtedly facilitated this. Furthermore, since this was a small education department that it mainly served the trust within which it was located, close links were further facilitated. Despite these obvious links, the case site was not immune to the general discussions concerning theory-practice gaps which have been highlighted elsewhere (Fealy, 1997; Jarvis, 1992; Rafferty et al., 1996), indicating the complexity of issues which contribute to bridging the gap; of which, geographical proximity is only one.

Saskia, an educator, talked about the limits to what can be learnt in the classroom and the importance of theory-practice links. In talking about the facilitation of self-awareness through reflection, she argued that this cannot be taught but has to be 'lived'. Her somewhat nebulous response exemplifies the current criticisms of reflection and reflective practice based on a lack of clear consistent definition of the term and highlights the lack of a consistently applied framework through which it can be taught (Mackintosh, 1998). Evidence to support Mackintosh's contentions can be found across the case sites.

Saskia was asked if she thought that students were given the opportunity through the classroom and placements to 'live' that experience:

> *'I think the opportunity is there. I think to a certain extent it may depend on the role models that they are with. I think practice is a very, very powerful teacher. I have always been remarkably humble about what we*

> *do in here. Here is theory and out there is practice and even though we do try to bring the two together, they are very often seen as separate. And I think what they are seeing in practice and how they are seeing midwives prioritise what they do and how they treat the women, it takes a student with fairly strong personal beliefs and self-awareness not to emulate that. But there are some very good midwives out there, which is just as well, really.'* (Saskia, educator)

Whilst Saskia raised the point of practice role models, Catherine, a student, drew attention to the necessity of appropriate role models in the classroom, mentioning in particular an aspect of Saskia's limitations in this respect:

> *'I find it difficult on this programme because, like Saskia, she put some really good ideas across of how you can practically get round situations or problems or invite women to take part in certain things. But she hasn't been in practice for a long time and if you were to do all the things that she said, your booking appointment would probably take 3-4 hours. So you need to have people who are up to speed with what is happening in practice. I think that is really, really important. Most of the tutors here do practice, but I think that is really important.'* (Catherine, student)

Many incidences were identified in which general links between classroom discussions and practice were made. For example, within a session on domestic violence, students were introduced to feminist ideas about domestic violence, and encouraged to think about the concrete ways in which they might work with clients in such a situation. However, there were relatively few instances in which students or educators were able to specifically follow through something that had been taught in the classroom and identify its impact on practice. Anne, a student, is an exception:

> *'[In the classroom] we went through the literature such as the Black Report. In the written work we had to talk about factors that can have an impact on your health. This has been helpful this term because I've been working out in [poor area of city]. When women tell me they smoke 20 a day I don't react as I might have done and understand that it might be their way of staying sane. It helped me step back and look around the area.'*
> (Anne, student)

A more general answer from Catherine is more typical than Anne's use of specific examples:

> **Interviewer:** *'How does what you learn in the classroom relate to what you learn in practice?'*
>
> **Catherine:** *'A lot more now. This term it has really pulled together. Before then there has been a real gap. Either your theory is ahead of your practice or your practice has been very ahead of your theory and it has been really frustrating and really quite frightening at times. And there is a big lack of awareness, especially on delivery suite, which there shouldn't be because the programme has been running long enough. But they will expect you to do things that you really have absolutely no idea about and that worries me … But certainly this term everything has gelled together and everyone is feeling a lot happier and a lot more like they know what they are doing.'*

Data from Case Site A highlight some of the challenges involved in bridging the theory-practice gap. It is likely that lecturers need recent experience of practice if they are to ensure that theory and practice are properly linked. The role of the lecturer-practitioner may be central here. It also seems apparent that it takes time for students to appreciate that the links between classroom theory and practice take time to see and appreciate. However, preceptors and other midwives need an awareness of what is occurring in the classroom. This may facilitate students making the links. The data suggest that preceptors and midwives are often relatively unaware of what occurs in the university context, an issue that relates to general debates within nursing and midwifery education concerning the limitations of current preceptorship arrangements (White et al., 1993). This issue is explored further in the analysis of Case Site B. Finally, students having a certain amount and type of practical experience of their own is clearly crucial to making these links.

#### 6.3.3.3 The importance of practice placements

In both the interviews and the classroom, students frequently drew on their own practice experience to explore the role of the midwife in relation to caring for disadvantaged clients. The sharing of practice experiences clearly enriched debates within the classroom setting, and students who had not worked with a diverse range of service users within the community setting were sometimes at a disadvantage in discussions.

Given the seeming importance of the acquisition of a range of experience, one might think that a specific policy would be in place to facilitate a broad range of practice experience. Perhaps surprisingly, this was not the case. In this sense, these findings support those of other researchers who found that students did not always have practice experience of working with, in their case, specific ethnic minority client groups (Gerrish et al., 1996). However, educators in Case Site A were clearly aware of this issue and attempts were made to ensure that students had access to different client groups. For example, an educator stated:

> *'I am not involved in community placements but we do try to place them in a variety of placements so that they have experience in different areas of [the county], so by doing that they should get exposure to different client groups. At the hospital they all work in [ward specialising in high risk pregnancies] so those are the women most likely to have medical complications. And [another area] specialises in bereavement work, here, so when you are having perhaps surgical terminations, but late on, or terminations for foetal abnormality or still births. We try to introduce that sort of thing, so that covers an enormous range of client groups … We try to get it so that students have been in city placements and more rural placements.'*
>
> (Shirley, educator)

Another educator, was asked whether students were taught about local inequalities:

> **Saskia:** *'No. We don't talk about the local population. They go out there and experience it. What we tend to do is move them around the areas if we can, so they don't always stick with one particular population.'*
>
> **Interviewer:** *'So is that something that you actually try to do?'*
>
> S: *'Yes. There is a limit on that of course, because we have got students without transport and because we try to give the students quite a bit of choice, there is a slight tendency for them to want to go back to where they are comfortable. We do cater for that a bit but we do say, well, it would be a good idea to try somewhere else because it is a different population that you are looking at. The midwives work in a different way and you need as broad an experience as possible.'*
>
> I: *'And do students generally respond to that? Do they see that as a valuable thing?'*
>
> S: *'In theory they do. In practice quite a lot of them do … but you can perfectly understand when you are saying "Do you mind just popping on the train to [village in county] every day?" they are not too happy about it.'*

Whilst none of the students interviewed drew attention to this practice, Veronica, another educator, also gave credence to the notion that students selected placements based on geographical convenience rather than to gain a broader range of experience. If there are, for such practical reasons, limits to the types of practice experiences some students have, what occurs in the classroom in relation to learning from educators and from other students becomes even more important. Reflection is one arena in which they may be encouraged to discuss their practice experiences with other students.

### 6.3.3.4 The importance of reflection

In Case Site A we did not consistently ask educators or students in interviews to name a model they used for reflection in use in the classroom. Most interviewees talked in general terms about the use of reflection as a device for exploring inequalities issues. An educator described how reflection was built into her practice modules:

> *'The practice modules that I am involved with, I think we all do it, we set aside time at the beginning of the session for students to reflect on their practice that week. We all throw up issues such as inequalities in service provision and type of care they have received so that is … again, we get it within the group. Often these days we don't have any answers, at least it is thought-provoking and makes them think about their own practice too.'*
> (Shirley, educator)

Shirley was clearly of the opinion that the lecturers use reflection as a means to explore inequalities issues but students differ here. Catherine, a student nearing the end of her programme, stated that the use of reflection depended on the lecturer, with some incorporating it more than others:

> **Interviewer:** *'Are reflective sessions included in your programme?'*
>
> **Catherine:** *'It depends on the tutor to be honest. Felicity and Shirley are both really hot on it and think it is really important and they always allow half an hour to an hour at the beginning of every session. Some weeks you will go round and everyone will say, "Oh no, I have had a really boring week". But like last term Natalie went out and assessed somebody at home and everything was hunky-dory, and met her in hospital and the baby had died in labour and obviously she needed to debrief. And I think I will really miss that once we have qualified actually, that we can't get together in a big group and talk about it.'*

Another student said that, in addition to these half-hour sessions at the beginning of practice modules, students were meant to use a 'reflective cycle' throughout their assignments. She found verbal reflection useful but described it in terms of debriefing and providing support for students concerning difficulties they had faced in practice:

> *'I think it's useful to know that, especially if you feel like you have made a mistake in practice or you've let yourself down or let anybody else down. It is quite useful knowing that other people make mistakes too and that they feel insecure like you do. And also you learn from other people saying what they did and what they did wrong. If someone has had a particularly good experience then they talk about that as well.'* (Lara, student)

On the whole, then, reflection was considered a useful way to undertake such exploration, but it was thought that reflection and reflective practice sessions needed both structure and a good facilitator if they were to be truly productive. A student nearing the end of her programme made this point very clearly:

> **Interviewer:** *'Can you tell me a bit about reflective sessions. Are they included in your study days?'*

> **Nicola:** *'Yes. They are. They have been since the second year, at the start of practice. Shirley is very good. If anyone needs to talk about anything it always gets discussed and she tries to include everything. But Felicity's sessions were quite infuriating really, because we were so aware that we didn't know anything. We hadn't done any midwifery and we used to come to sessions. We would do reflections on practice, it went on forever, and she would say "What do you feel like doing today?" and we were like, "There must be a structure to this degree, we have got to qualify". What are we going to do? You know, qualify, and realise we don't know what a post-partum haemorrhage is or something. This was in the second year.'*
>
> I: *'So was there too much reflection?'*
>
> N: *'Too fluid. Not enough structure. Shirley has been brilliant. She does reflection, but it is very structured and in the last two terms we have learnt more than we have learnt in the rest of our degree without a doubt.'*

Natalie, another student nearing the end of her programme, also commented on the need for structure, although she enjoyed the long unstructured sessions at times.

During the classroom observations, although many instances were observed in which students were encouraged to draw on their own practice experience, there was little in the way of explicit reflective practice using specific models. However, one educator stated that she explicitly used a particular model, and photocopied a diagram of the model for the interviewer. Since we were unable to observe any of her classes, it is not possible to comment on her use of this.

From these accounts of the use of reflection, it appears that there was no particular model or framework for reflective practice used across the curriculum in Case Site A. On reading a draft of this chapter, Felicity, an educator, suggested that *'Gibbs (1998) is undoubtedly the most widely-used model of reflection within the department. However, students are introduced to a variety of models, but their model of choice is usually made explicit in their written reflection'.* Our impression was that those lecturers who used reflection did so largely implicitly, and in accordance with Schön's notion of 'reflection-on-action' explored in Chapter 4. For students, the reflection sessions that worked the best were those that were well structured. This is clearly an area which could be strengthened to improve students' abilities to use this technique.

#### 6.3.3.5 The assessment of understanding of inequalities issues

The issue of assessing understandings of inequalities is clearly complex. Whilst setting essay questions which assess a student's conceptual understanding may be relatively straightforward, attention has been drawn, particularly in the social work context, to the difficulties of assessing student attitudes and values (Preston-Shoot, 1995).

In Case Site A, there appeared to be more attention paid to assessing inequalities issues in practice through the use of practice-based competencies than in written assignments in the university context. However, as some participants pointed out, there was not always a clear distinction between theory assessments and those of practice:

> *'Well, there is a competency assessment, which you mentioned. There are the learning contracts which are designed to enable them to fulfil the learning outcomes for the modules but incorporates quite a lot of reflection on the practice that they have seen, and become involved with. It is actually quite difficult because we always try to combine the two, so even if they are doing a theoretical module that supposedly does not have any practice in it, they will still be addressing practice and they will be asked to provide examples from practice. So none of it is that divorced.'*
> (Saskia, educator)

119

This issue came up again in a discussion group held with a group of students nearing the end of their programme. They were talking about the assessment criteria for the learning contracts that states that they must link theory and practice, but, as one student pointed out, this was not always possible. In the context of a learning outcome that says that they must show awareness of multicultural issues, for example, their limited practice experience may have been an impediment here:

> **Student 1:** *'Yes. You have to bring it [multicultural issues] into most of our essays and assignments because it is always there in a learning contract but it is never in detail.' [Felicity, an educator, informed us that this was not actually the case: 'Students would not have to address multicultural issues specifically in a learning contract unless this was stated within the learning outcomes for the module.']*
>
> **Student 2:** *'And unless you actually choose to look at Asian culture, or whatever, then it won't be in-depth.'*
>
> **Student 1:** *'But then you can't do that because you are supposed to relate theory to practice so if you haven't had experience of caring for Asians then you can't really do the theory on it.'*

Curriculum analysis identified ways in which practice assessments in the early stages of the programme required students to demonstrate self-awareness. Later in the programme they were required to demonstrate evidence of having developed themselves as 'non-judgemental' practitioners.

In relation to assessing attitudes, a student talked about the 'reflective cycle' as used and assessed in the learning contracts on the practice modules. She was responding to a question about how inequalities issues were assessed, and her remarks suggest that students do not always appreciate the methods used for such assessments:

> *'You get quite heavily marked on your reflective cycle. So you have to go through what the situation was, what you were feeling – which is of course going to affect the way the person you are interacting with is feeling – what your actions were, what happened, how you felt afterwards and how you felt having read something or having spoken to somebody or whatever. So you have to do that all the time and everyone hates it, everyone lies. Everyone makes up these incredible women with these incredibly complex lives, which are like six different people pulled together! I can see the value of it. I find it very difficult to write it down in a way that other people can understand. And my tutors will say to me "But why, what happened there that you were thinking that?" … You are driving home in the car and you think "That was an awful day" and maybe if I had done this so and so wouldn't have reacted. So I suppose it is good, if you don't do it, then it is getting into the habit of doing it.'*
> (Catherine, student)

Thus despite the fact that students may have mixed feelings about the value of their reflective assessments, they are clearly unable to completely escape reflecting on their feelings in relation to events. However, how these are translated into a written format can be challenging. A number of writers question how these can be used for assessment, given the personal nature of the reflection process (e.g. Holmes, 1997; Walker, 1985). In the following quote, Catherine draws attention to the difficulties of incorporating different paradigms (in this case scientific and humanistic) in one context:

> *'… if you go and ask any year of midwifery, they will always tell you that they hate their learning contract because you have to do that [reflective cycle] and you have got to get all your theory in, all in a 3,000 word*

> *assignment and so you are switching from so and so's controlled trial says this … to "I was feeling …".'* (Catherine, student)

When asked about whether or not students are required to address inequalities issues in their assessments, an educator, replied:

> *'I think they can't get away without doing so. The number of times we end up writing "broad sweeping over generalisation" on things.'*
> (Saskia, educator)

A lecturer-practitioner also talked about how inequalities issues were addressed in theoretical assessments. However, she felt that they were addressed in a rather non-specific and vague way:

> **Interviewer:** *'In their theoretical written work, are students required to demonstrate an understanding of inequalities in health?'*
>
> **Veronica:** *'I would have to sit and look at all the learning outcomes of all the modules but I don't think that comes across specifically. Take for example, my module, there is a learning outcome which goes something like, "understanding the broader context of child bearing or midwifery" … I can't remember how it is worded, and some examples are given like multi-cultural society, demography, technology. So it is in there if you look for it but it wouldn't hit you between the eyes."*
>
> **I:** *'Do you feel a student could get to the end of the programme without having an understanding of inequalities or …?'*
>
> **V:** *'I don't think they could get to the end of the course with no understanding but I do think it would vary and that some would be much more aware than others.'*

There was some agreement amongst participants that assessments relating to inequalities issues were sometimes more implicit than explicit. However, some educators provided clear examples of how they expected students to incorporate such issues, even in assignments that appeared more general. For example, Saskia pointed out that demonstrating the ability to tailor care to specific clients was implicit even in a seemingly generalised assessment which asked students to discuss diet in pregnancy:

> *'[I would] expect them as part of the learning outcomes to say "Well. For example, if I was talking to somebody on a low income, I would have to find out what it was that they could possibly afford and try to tailor the advice around that."'* (Saskia, educator)

In summary, and in line with the results of the curriculum analysis in Case Site A, it seems that there is no absolute requirement that students in this site demonstrate understanding of inequalities issues in the midwifery context in their assessments, either practical or theoretical. Students seemed confused about what is required of them; one claimed they invented stories of women with complex problems rather than draw on their experience of women they had actually worked with. One lecturer clearly believed that it would be possible for a student to reach the end of her programme with little understanding of inequalities issues due to the rather vague and non-specific way in which such issues appeared in the assessment criteria. These issues are certainly not specific to Case Site A, as the reader will see when the issue of assessment in another case sites is discussed. This is another area in which there is room for improvement in relation to midwifery education strengthening its commitment to teaching and learning about inequalities.

## 6.4 Conclusion

Having introduced the educational, geographical and midwifery context, this case site analysis explored the different ways in which participants thought about issues of inequalities and disadvantage. It was clear that the concept of 'individualised care' was important in framing responses in this site. We then went on to consider the type of knowledge, skills and attitudes midwives need to develop in order to care for disadvantaged women. In particular, knowledge of women's social and cultural backgrounds, as well as a clear sense of the role of the midwife in relation to tackling inequalities was emphasised. The notion of working towards having a 'non-judgemental' attitude was deemed to be an important developmental goal for midwives in this case site. However, many participants drew attention to the fact that such attitudes were not always present.

The final section of the chapter addressed the issue of educational provision in relation to teaching and learning about issues of inequality. Inequalities issues clearly permeated through the curriculum, although the manner in which they were taught varied greatly.

Some of the issues that arose in work initiated in the classroom context and that undertaken in practice were explored, and the value of practice placements in a broad range of settings in areas which students were unfamiliar, was clearly identified. Finally, the fact that there was no clear imperative in Case Site A for students to be assessed on issues of inequality was discussed.

The following chapter mirrors the format of this one, exploring issues of midwifery practice and education in relation to a very different context, Case Site B, in a large town with a high incidence of social and economic deprivation.

### Key Points

- Case Site B was in an area with relatively high levels of social deprivation. The midwifery education department was large. Both 18-month and three-year midwifery pre-registration programmes were available.
- Curriculum documentation revealed that the early part of the programme introduced the students to concepts such as need, equity, choice and control, in relation to practice. In addition, a link was made between complex social issues and health. Analysis of the curriculum indicated a strong feminist agenda, and a focus on *Changing Childbirth* (DoH, 1993).
- Some written assessment tasks were likely to address issues of inequality but the focus on inequality within the assessment was not compulsory. This was a common finding across all three sites.
- There was little mention of individualised care in relation to equality of care. Rather the emphasis was on social class and local geographical inequalities.
- Midwives suggested there was a connection between inequalities in health care provision, and the expectations, demands and needs of women in various social groups within the locality. This had an impact on the way in which midwives worked, and the allocation of resources.
- It was suggested that more affluent women demanded and received greater midwifery input than those who were socio-economically deprived. Indeed, the view was that the latter group tended to be suspicious of midwives and concerned about their potential surveillance role. This, however, was not borne out in interviews, with many such women speaking highly of community midwives.
- In relation to disadvantaged clients respondents mentioned 'teenage mums', the disabled and ethnic minority women.
- In common with Case Site C, this site had link workers for some ethnic communities. There was concern however that these services should be extended, and that midwives should become more familiar with particular cultural mores.
- Knowledge and understanding of the social and cultural context of women's lives were deemed important. This was perceived to be best obtained through appropriate placements in the community.
- Some women, community and student midwives spoke of hospital midwives showing a lack of awareness and understanding regarding the social aspects of the women for whom they were caring. In particular, judgemental attitudes towards teenagers and drug users were cited. Students reported witnessing prejudice amongst midwives which included talking about women in a derogatory manner behind their backs.
- There were joint education-service fora, and respondents felt that this liaison was reflected in close theory/practice links.

## 7.1 Introduction and background to Case Site B

Case Site B was in a northern city with a high incidence of social and economic deprivation. It had a smaller population of ethnic minority residents (4%) than Case Sites A (9%) and C (42%). A relatively large midwifery department within a university provided midwifery education to several trusts across a large geographical area. There were approximately 25 members of academic staff, most of whom were of white British ethnic origin. The student body consisted of approximately 140 pre-registration midwifery students, also primarily of white British origin. At the time of the study, approximately 40 were on the 18-month pre-registration programme and 100 on the three-year pre-registration programme. The department also provided a wide variety of post-registration education including a Masters degree programme. Service providers were involved in the student recruitment process.

A programme leader was responsible for overseeing each programme, as well as unit leaders responsible for individual units. Each staff member was attached to a practice area and was responsible for maintaining contact with the midwives and students in that area. There was a regular midwifery forum, chaired by the head of midwifery education, for practitioners and educationalists.

One of the trusts served by the education department was the focus of the research. This trust also provided its own in-house education on a number of subjects.

The hospital was located within the city centre and served a relatively socially and economically disadvantaged population, compared to Case Site A. There were approximately 6,000 deliveries per annum within this unit. Only 0.5% per cent of these were home births – well below the national average; however, recent statistics showed the home birth rate to be rising. Twelve per cent of births in this trust were to teenage women, hence many service users referred to us by midwives were teenage mothers.

Within the maternity unit there was an ante-natal clinic, ante-natal admissions ward, two post-natal wards and a delivery suite. There was also a special care baby unit (SCBU).

The maternity services also comprised of 35 community midwives and two maternity link workers. Parent education classes were led by community midwives within their respective patches. One midwife had the role of developing parent education.

The community midwives were managed by the community manager, based at the hospital. There were two systems of community midwifery currently in place: a 'traditional' service and a 'team' service. The teams, set up as a result of *Changing Childbirth* (DoH, 1993), aimed to cover all midwifery care including intrapartum care, while the traditional community midwives provided ante-natal and post-natal care and the occasional domino or home delivery. The provision of two different types of community care caused much discussion and debate throughout this site. Allocation was purely dependent on GP registration, and many midwives saw this as a two-tiered system and therefore an inequality in services.

The community midwives served a diverse population. The ethnic minority population mostly consisted of Asian people living in a concentrated area of the city. There was also a small Chinese population living mainly in the city centre. In addition, there had recently been an influx of Kosovan refugee people.

Two part-time maternity link workers were employed to work alongside midwives; one was Bengali speaking and the other worked with the Chinese community. For non-English speaking/reading service users there were leaflets in the following languages: Hindi, Bengali, Gujarati and Arabic.

For teenage parents, there was a weekly drop-in session with a midwife, health visitor and rights worker. As in Case Site A, this provided informal parent education. There was also a school for young pregnant women and mothers, to enable them to continue their education.

The community midwifery services were organised into four areas. The area that became the focus of the study had high levels of social and economic deprivation, and was often targeted for resources including a Sure Start project. The area had a high incidence of teenage pregnancy, especially among Caucasian service users, and a high incidence of non-attendance for ante-natal care and of child protection cases, compared to other parts of the city. The majority of the Asian population lived within this area.

Midwifery care was provided by midwives working in the traditional community way and also by a team of midwives. Interviews were conducted with three midwives from the traditional group, two in the team, students who had worked with them, 15 service users and one maternity link worker. One of the midwives co-ordinated the teenage pregnancy drop-in service, and also visited the school for pregnant teenagers and teenage mothers once a week to provide parent education and ante-natal checks.

In addition to the midwives, a wide range of lecturers, students and other service providers were interviewed. Observation was carried out in both educational and service provision settings, and a qualitative curriculum analysis was undertaken.

## 7.2 Curriculum analysis of Case Site B

Data sources for this analysis were the questionnaire completed by a senior educator at Case Site B and the curriculum documents provided from the educational institution. We also drew on data collected during observation of teaching sessions.

The pre-registration programme, on which the respondent's answers to the questionnaire were based, was a unitised honours degree for non-nurses (to avoid confusion, programme units are referred to as modules). The philosophical statements selected by the midwifery lecturer who completed the questionnaire specifically mentioned the need to avoid stereotyping and to be sensitive to religious, cultural and linguistic needs. Furthermore, they recognised the special needs of local communities, including ethnic mix, numbers of teenage, unsupported, homeless or older mothers by taking a feminist and social perspective. However, the following statement identified by a researcher was not reported by the lecturer: '... *to enable them [students] to respond to cultural, political, sociological and economic changes*'. This may have been because the lecturer perceived this to be a responsive rather than a proactive stance of advocacy. Analysis of the selection of statements indicated that the lecturer had interpreted the brief regarding the identification and provision of care to disadvantaged service users very literally, and seemingly more peripheral and yet relevant statements regarding issues such as the provision of woman-centred holistic care and the contribution of the multiprofessional team, were not included.

### 7.2.1 Main features of the pre-registration curriculum

The main features of the pre-registration curriculum at Case Site B can be summarised as follows:

- the themes running through the programme were: biological and physical sciences, the role of the midwife, woman-centred care, appropriate and accessible care, reflection in practice, research awareness, communication skills and psychosocial aspects of care
- the context in which appropriate and accessible care is delivered was the starting point of the programme; midwifery processes and models were introduced which enabled an individualistic approach to care, based on women's needs, wishes and views
- communication skills underpinned the midwifery process, and 'stereotyping' was addressed
- normal midwifery in ante-, intra- and post-partum modules was specifically related to the special needs of the local communities
- the second year of the programme moved into ill health and at-risk situations
- the third year highlighted advocacy, choice, autonomy, ethics and morals together with critical evaluation of availability, accessibility and quality of services
- the majority of modules were midwifery-led, although four in Year 1, taught by non-midwives, were shared with student nurses; two have direct relevance to this study, and were concerned with social policy and its implications for health care provision, and psychosocial influences on health behaviour and care; a midwife teacher was associated with each module and was responsible for making the theories introduced by the non-midwifery lecturers, relevant to midwifery

- according to the curriculum document, students commenced placements in the community then moved into hospital to be involved with woman-centred care; they returned to the community in the second and third years
- eight midwifery-led modules had clinical evidence assessments, which contributed to classification
- elective placements could be taken either in other NHS trusts or other countries.

### 7.7.2 Key findings of the analysis of pre-registration curriculum documentation

The key findings of the analysis of the pre-registration curriculum documentation at Case Site B can be summarised as follows:

- programme and module learning outcomes closely reflected the philosophy
- seven out of 24 module were identified as having direct outcomes relating to inequalities in health and/or health care provision; non-midwives led two of these
- although no specific theoretical assignment addressed inequalities in health and health care provision, the questionnaire respondent indicated that it was likely that students would choose to do so in at least one of six modules; furthermore, curriculum analysis indicated considerable scope to focus on these issues
- continuous clinical assessment required the achievement of core activities common to a range of professionals as well as some specific to midwifery; achievement was measured using performance criteria, the standards of which were raised each year, thereby increasing the challenge for students as the programme progressed; activities included: awareness of the nurse/midwife as an advocate (Year 2), showing respect for and sensitivity to the individual needs of clients (Year 3), considering the needs of non-English speakers and people with sensory impairment in parent education. This was unusually specific compared to the rest of the curriculum; many statements were vague and generic, as most were aimed at preparing students to meet the needs of diverse population
- a strong feminist agenda of power and control was evident in curriculum documentation and teaching
- a further prominent feature was that of the *Changing Childbirth* (DoH, 1993) tenets of choice and continuity
- 'special needs' was a theme running through the whole programme rather than isolated in a dedicated module
- the programme used representatives from race relations and a disability liaison officer in specific teaching sessions; visits were arranged to a women's refuge and a teenage pregnancy unit
- midwifery lecturers had undertaken academic studies in women's studies, equal opportunities and social policy
- one nurse lecturer had a specialist interest in profound hearing loss and there was a module on this subject.

### 7.2.3 Exemplar of a module addressing the issue of inequality

The module selected as an exemplar for Case Site B was concerned with communication and counselling skills; it ran in the first semester of the programme, whilst students were in community placements. Students were expected to examine 'inter- and intra-personal skills', and the impact of gender variations on communication. Module outcomes did not require a change in students but expected them to understand communication theories and their relevance to midwifery. The content included self-awareness and assertiveness training and the teaching methods employed experiential techniques and critical incident analysis.

On an observed teaching session, experiential learning was used and all students participated. They were encouraged to consider themselves as others might see them, as well as to consider factors that might affect the way other people behave. The lecturer did not ask students to reveal their own values and beliefs, so there was no opportunity to challenge stereotypes at this point. The lecturer used a reference to lesbian couples within a communication model as an illustration of aspects of the sexual self; however, as this was merely used as an illustration, an opportunity to challenge students' attitudes may have been lost. Buber (1979, cited by Sadala, 1999) suggests that there are two ends to the spectrum of possible reactions to this illustration, from 'establishing distance' to 'starting relations'. The latter demonstrates a willingness to open oneself to the other person and allow the possibility of effective communication.

The assessment task was a self-assessment of communication skills. Although the learning outcomes were phrased in such a way that students were only required to understand communication theories, in fact the assessment task expected students to improve their own interpersonal skills.

The clinically assessed core activity in Year 1 required students to be able to introduce themselves, establish and maintain eye contact and include other family members in conversation. Other clinical activities related to multiprofessional teamworking e.g. ability to take a telephone message, introduce themselves and share information. This seems very low level in terms of the module content and methods, however such skills are clearly essential for good midwifery practice.

Nevertheless, it was clear from this curriculum analysis that there was significant coverage of issues of inequalities in the programmes at Case Site B.

Additionally, analysis of the curriculum documentation for the post-registration diploma and degree programmes indicated that three core compulsory modules allowed for the needs of the individual to be explored in relation to contemporary health care policy and existing provision for women's health; these were concerned with health policy and motherhood, female sexuality and health, and women as a focus for practice development.

## 7.3 Key themes and issues from the research data

This section explores the key themes and issues which arose from the interview and observation data, from both educational and practice data sources in Case Site B. Table 7.1 summarises the data collected at Case Site B.

127.

| Type of data | Description | Number | Duration (hours) |
|---|---|---|---|
| Interview | Focus group with midwifery students | 1 | 2 |
| | Interviews with midwifery students | 5 | 7 |
| | Interviews with preceptors | 5 | 9 |
| | Interviews with service users | 16 | 21 |
| | Interviews with midwifery service managers | 2 | 4 |
| | Interviews with midwifery tutors | 4 | 8 |
| | Maternity link worker | 1 | 1 |
| | **Subtotal** | **34** | **52** |
| Observation | Classroom observation | | 18 |
| | Practice observation | | 10 |
| | **Subtotal** | | **28** |
| **All data** | **Total** | | **80** |

Table 7.1: Data collected at Case Site B

### 7.3.1 Reflections on inequality and disadvantage

As in Case Site A, with the addition of a maternity link worker, midwifery managers, midwives, lecturers and students were asked to reflect on the meaning of terms often associated with inequality and disadvantage and to say how they understood them in the midwifery context. A striking feature was that in Case Site B there was less explicit mention of the concept of individualised care than in Case Site A, either to endorse or to refute it. On the whole, participants emphasised the structural nature of inequality, drawing attention to issues of class and geographical inequalities. Some also gave specific examples concerning the limitations of health professionals in meeting the needs of disadvantaged service users. Others appeared to suggest that, to some degree, inequalities in health care provision were connected to cultural differences in the expectations, wants and needs of different social groups. These differences then impacted on the manner in which midwives worked and the way in which they allocated resources. The degree to which respondents articulated a desire to challenge their own practice and/or that of other health professionals to ensure a more equitable distribution of care varied. However, midwifery educators were more inclined than other participants to make statements that most radically challenged current care and the distribution of resources.

In the post-registration student discussion group, Jenny pointed out that geographical inequalities persisted, both in relation to midwifery services and health care treatments. She mentioned the fact that team midwifery had been set up in selected parts of the town only. Therefore women who did not live in those areas were potentially denied the opportunity for continuity of carer. Others in the group agreed with her.

A community midwife reflected on the term 'equality of care' by highlighting a number of issues. She began by comparing two areas of the city and two groups of women who she clearly felt got very different care in terms of amounts of time spent on visits. When asked to comment on 'equality of care to all women' she explained this in terms of the different expectations of the two groups:

> *'I'm immediately thinking [affluent area of the city] versus [poor area of the city]. [The affluent area] is the posh de la posh in the city and [the poor area] is somewhere in the mud in some people's eyes. If you say,*

> *"Right we are really busy, ask somebody from another area", it always seems to be that somebody will tell us that the midwives in [affluent areas] are busy but in a different way. They might have two or three visits today but each visit is expected to last an hour and a half to two hours because their women have got higher expectations and have higher demands of midwifery time. They will have like an A4 page of questions waiting for the midwife. So the midwife can't just go in and say, "Ah, that rash is nothing". She has to explain what it is called, how long it will last, what colour it will turn, what cream to rub on, what cream to rub off, blah, blah, blah.'* (Clare, community midwife)

Clare went on to draw attention to the notion that some of her clients were suspicious of her input:

> *'In [poor area] if you are in the house longer than twenty minutes they are very suspicious, why are you hanging about? A lot of my clients have been, and are, criminals … You have to think I want to come back in here tomorrow because this baby is jaundiced. So you are there very quick and you are out. And you do your thinking outside rather than sitting as a partnership with a woman, thinking with her and wondering what it might be … Equality of care to all women, why can't the women of [poor area] have an hour and a half of midwife time? Just because they only need you in the house quick, it means we get used to doing ten visits, not two or three, which is a bit unfair.'* (Clare, community midwife)

For Clare, then, the differences in care given to these two groups can be explained and, possibly in part, justified, in terms of the group's different needs and expectations. The more affluent women want to talk about everything, the more socially and economically-deprived women are 'suspicious' of midwives and want visits to be short.

Interview data with five of Clare's clients suggests that they were, on the whole positive about her involvement in their care, although some had very negative views about other health professionals who had been involved in their care. However, when describing Clare's input, they used words like 'friendly' and 'nice'. One client, Vanessa, did comment that the health promotion aspects of her care could have been improved, but she then went on to speak very positively about her relationship with Clare:

> **Vanessa:** *'I think Clare understands, but I don't think a lot of them do. They say that they do, but I don't know. I feel like I'm the only one who's going through all this stress and everything.'*
>
> **Interviewer:** *'How does she make you feel that she understands?'*
>
> V: *'Because she is always constantly asking if I'm all right, and she will say "Oh you don't look very well" or "Are you all right?" and "What's the matter?" She's always been like that and she says I really shouldn't be at work and stuff like that, after having a section and going back so early. I think she understands because she's got kids of her own as well.'*

Thus it would seem that although Clare interpreted her disadvantaged clients as seeing her primarily as surveillance professional, clients did not seem to share this perception. A further analysis of the five interviews suggests that Clare spent considerable time with some of these clients, and that they were happy to receive advice from her. Their satisfaction with her care may, of course, be in part due to the degree of attunement she had to her clients' needs, and her sensitivity to her potential surveillance role. However, another interpretation is that Clare may have referred us specifically to service users with whom she had a positive rapport. This issue reveals a potential weakness in the approach taken to data collection and gate keeping in the study.

129

No other interviewees mentioned the potential for midwives to be seen as surveillers of their clients. As in Case Site A, other interviewees made the point that midwives were perceived to be different from professionals such as social workers or health visitors. For example, in the post-registration student focus group there was general agreement that service users generally liked midwives and that social workers and health visitors were generally disliked. One participant suggested that if midwives tried to deal with all their clients' problems they would be disliked as much as health visitors.

Comments from another community midwife are relevant to this discussion of Clare's relationship with her clients. Like Clare, she acknowledged that some women do not receive the input they need because of the short time spent on the 'booking interview'. She was reflecting on which groups midwives should be targeting and explained what she meant by this:

> *'Just the people that need the input often don't get it because they put barriers up themselves. A lot of the times you can go into problem houses near [area], I mean, I can do a booking in some houses in half an hour. Bookings shouldn't take half an hour but they say "Yes, no" … Often the booking is the time when you can find out most and be able to help them.'*
> (Pat, community midwife)

Thus, Pat suggested that women may be partly responsible for inequalities in midwifery provision because they 'put up barriers themselves'. Another community midwife, offered an alternative perspective on the issue of time and inequalities. In explaining her caseload, like Pat and Clare, she compared it to those of midwives working on the other, more affluent, side of the city:

> *'… some people have a very smallish caseload but you have to look at the women they have as well. Some of the women on [the affluent side of the city] are very demanding, their parentcraft sessions are huge. They have tons and tons of time, just to spend with them, just even one to ones. Whereas, that is a different kettle of fish to this end. We are writing letters for housing and taking them along and making sure they were going for hospital appointments. Following up defaulters much more … We can do post-natal visits quite quickly whereas you could be an hour and a half at somebody else's house, two hours maybe, the other side of the city. So sometimes their caseload is a bit smaller … At times it gets you down.'*
> (Jo, community midwife)

This account is interesting, as it seem to imply that the size of a caseload reflects the demands (or lack of them) made by different client groups. Although Jo did not mention the concept of individualised care, her statements could be interpreted within this frame; different women 'needed', or demanded, different amounts of time allocated to them. However, at another level, Jo seemed to be saying that these differences in demands were related to issues of inequality and disadvantage. It is then perhaps surprising that, although Jo initiated this discussion of resources within the context of being asked about inequalities, she did not reflect explicitly on the issue of unequal allocation of resources. Rather, she seemed to accept that, in this context, it was appropriate to allocate resources unevenly in order to reflect demand (or lack of it). Her statements here would seem to fit implicitly with the liberal humanist philosophy of individualised care, rather than being founded on an anti-discriminatory or anti-oppressive rights-based philosophy. Tyler's reflections on the relatively apolitical stance often taken by midwives is relevant here (Tyler, 1994), as is Crafter's analysis that, within the maternity services, the distribution of health care *'is often dependent on socio-occupational status rather than need'* (Crafter, 1997: 34).

Going on to be more explicitly critical of the work health professionals did with service users in her caseload, Jo spoke of the way in which the expectations of midwives and other health professionals can directly influence their approaches to care and result in inequalities:

> **Interviewer:** *'When you say you don't know if they are always offered it [information], how do you know?'*
>
> **Jo:** *'Things like when a woman goes to her GP to say "I'm pregnant" or whatever. I think if you were in a different area [the GP] would say, you know, "Obviously you don't take this or eat that" … like, folic acid. It's particularly more important down where I work that they have folic acid because their diets are not brilliant to start with. I think sometimes the GPs forget and they just think things like "smoking". They are the first contact for these women. I think that they just accept that these women smoke and they don't say anything. Basically when a woman comes to you saying they are pregnant this is the information they should be getting no matter where they're from or what they do.'*

Jo continued to reflect on the difficulties of ensuring that some women receive the health information midwives perceive them to need. She felt especially strongly that women from more socially deprived areas did not attend parentcraft classes.

Jo's dilemma in relation to parent education classes is reflected in the midwifery literature (Collington, 1998a; 1998b; Priestley, 1997). It is important to try to establish the extent to which these women are actively rejecting classes. One explanation endorsed by the literature is that the ways in which information is presented does not seem relevant to some service users, and that it reflects dominant cultural values and understandings.

Discussing the lack of attendance of Bengali women at parentcraft classes, a maternity link worker, offered a further explanation:

> *'Actually they are busy ladies. Some of the husbands want to go to work very early, they come back about two o'clock, so they have to, before two, they have to cook a meal for the husband and also the children as well. They come at three-thirty or three. So they don't have time and also they do prayers five times a day … And some of them are living in an extended family like a mother-in-law, sister-in-law, so it is a busy life for them. Young girls who are pregnant, they might marry and come to live in this country but they don't let them go outside. They'll go with the husband but not by themselves.'* (Nanda, maternity link worker)

The dominant design of parent education in all case sites was of early evening classes. This model is clearly designed with the primiparous woman and her male partner in mind, enabling them to attend after work, and in part reflects an agenda of accommodating the needs of male partners. However, for many of Nanda's clients and service users in Case Site C, it was clearly not appropriate. Primiparous women from some cultural groups live within large extended families and have extensive domestic commitments. During the feedback session, the point was made that specialist parent education provision was being developed in collaboration with a local Asian women's group. This may address some of the issues raised here.

Some of the most explicit criticisms regarding the targeting of care in response to the 'demands' of different women rather than identifying 'needs', came from educationalists rather than midwives. Nevertheless, across the case sites, even though there was some discussion of women's needs, there was little mention of clients 'rights', a notion which is common in anti-oppressive discourse (Preston-Shoot, 1995).

Peggy, a midwifery manager, reflecting on the term 'inequalities in health' was one of the few interviewees who expressed the idea that inequalities might occur in more affluent households. Interestingly, the other two midwives who expressed this view were in similar managerial positions, one within Case Site A, and the other in the pilot stage of the study. Although she mentioned the *Black Report* and clearly recognised the needs of women from

131

what she termed 'the lower social classes', she also articulated the notion that other clients could experience inequalities:

> *'My concern is that we might take away from people who actually still have a need as well. So I think it is getting the balance... Because you will find that the mums in [one area] are different to the mums in [another area]. And it is the mums in [affluent area] that sometimes have more post-natal depression. They aren't actually surrounded by a nuclear family ... Partners work long hours. So they have a need.'* (Peggy, midwifery manager)

Interview data with women go some way towards supporting Peggy's contentions. Although some sociologists refute the stereotype of the close-knit working class households depicted in ethnographic studies such as those of Young and Wilmott (1986), most of the women interviewed from lower socio-economic groups had considerable contact with their extended families. Other family members were often present when interviews took place, or would telephone and/or pop in during the course of the interview. For example, when Martha and her boyfriend Tony were interviewed, Tony's dad was watching television with them. Both Martha and Tony spoke about how much support they received from their families, how they saw them daily and shared child-care with other family members. Martha and Tony's baby was born with a disability and, reflecting on who had helped them most during the first few weeks, in which Martha, in particular, had found it difficult to come to terms with her daughter's impairment, she said:

> *'Just the family. All being there and saying don't worry about anything. Just all love her. She's spoilt, she gets everything, she's got too much. I tell people to stop buying her things.'* (Martha, service user)

Peggy's point concerning individual experiences of disadvantage and how these might manifest in ways which do not replicate structural inequalities is important and has consequences for midwifery education. Nevertheless, there was a tendency for a minority of respondents in Case Sites A and B to emphasise what might be considered relatively minor disadvantages amongst more affluent service users at the expense of those who experienced major, enduring constellations of disadvantage. This tendency did not occur in Case Site C, probably due to the chronic and extensive inequalities in this area; everyone seemed to agree on what constituted disadvantage, although they had different ideas regarding how it should be tackled.

Many midwives in Case Site B reported that women in the more affluent areas, with greater social capital, received more midwifery time and attention. If this was the case, it could perhaps be interpreted as a direct reflection of Peggy's self-reported ideology. Managers are in a position to address such issues and may become more accountable in relation to addressing inequalities as a result of policy drives such as *Making a Difference* (DoH, 1999a). These issues are explored in Chapter 9.

After giving her views on 'inequalities', Peggy went on to discuss disadvantage. She mentioned specific groups, including teenage mums and the disabled. In her discussion of young mothers she was keenly aware of the socially constructed nature of this disadvantage and its historical specificity:

> *'I know they are going to have a big drive to reduce teenage pregnancy and I'm not opposed to that but I think to say a teenage mother is a bad mother is wrong... A lot of mums years ago were teenagers. We've changed the boundaries ... We'll always have teenage pregnancies no matter if you plough billions into it ... What we have to do is look at how we deal with that and how we support them.'* (Peggy, midwifery manager)

Peggy's reflections concur with those espoused in a recent article in which Baker (1999) highlights the manner in which young mothers are in danger of being pathologised by current mores developed in the wake of Government policies which aim to reduce teenage pregnancies (Baker, 1999). Mander (1999) mirrors this concern and adds that this has been exacerbated by the 'epidemic' of books and articles on the subject both in the lay media and the professional press. Awareness of the socially constructed nature of contemporary attitudes to young mothers was prominent amongst midwives and midwifery managers in Case Site B.

Regarding care for disabled service users, Peggy was critical of her own hospital's facilities and practices:

> Peggy: *'I think the disabled are socially disadvantaged. I have to say I don't think we do an awful lot for the disabled.'*
>
> I: *'Do you get a lot of disabled pregnant women?'*
>
> P: *'We don't but it doesn't mean they don't have a need. I would be embarrassed to take you round this department to see how little the facilities are for women who are disabled. We do have disabled toilets. Who doesn't have a disabled toilet? I don't think we should pat ourselves on the backs for having that. If you saw the showers you would die. You would not get a wheelchair into the showers.'*

Peggy's concerns about facilities for disabled service users were shared by many informants across the case sites. Campaigners working on maternity policies, who were consulted during the project, also highlighted this issue. Furthermore, Peggy's comments endorsed those of writers in the field (Wright, 1997). She contrasted the provision for disabled service users with the approach taken to the needs of ethnic minorities. Here, Peggy felt that the support mechanisms were quite good (including two part-time maternity link workers), although with room for improvement.

As in Case Site A, there were few data directly from ethnic minority service users who spoke little English. However, one interview was conducted with Madhur, a Bangladeshi women, using the maternity link worker as an interpreter. Also, one fieldworker had a long conversation with a Bangladeshi taxi-driver *en route* to an interview. This concerned his needs and those of his Bangladeshi wife who had arrived in Britain six months before giving birth to her baby, who was now three weeks old. Neither Madhur nor the taxi-driver identified much dissatisfaction with services. However, on analysing the data, both service users seemed to have very undemanding expectations.

On the whole, link worker Nanda felt that the link worker service worked well and that it was important to provide this service to service users who spoke little English. However, she pointed out that more Bengali-speaking link workers were needed, particularly outside office hours, and felt that there was a lack of link workers for women who spoke other languages.

When asked about equality of care, an educator focused on the issue of physical access to the service. She discussed the recent closing down of two maternity units and the centralising of services around one main hospital:

> *'It was a move away from a group of women who had difficulty in terms of travel etc. and they moved the service further away from those women.'*
> (Bonnie, educator)

Bonnie also felt that this move resulted in a more 'clinical' and 'exclusive' approach to childbirth which, again, she did not feel was necessarily an improvement. She also made some interesting observations about structural issues when asked about the philosophy of woman-centred care which is so central to midwifery culture:

> *'I think [woman-centred care] is something that is paid lip-service to be honest. I think it is a principle that guides the maternity service only when they feel like it. It is something that has been used to get money in that has not necessarily been spent on women. I do think that the midwives*

> *embrace the principle because it captures a lot of what they would like to do for women.'* (Bonnie, educator)

A student talked about equality of care and suggested that the rhetoric ran throughout the programme but, in practice, there was still a great deal of prejudice:

> *'Most of our lectures are based around this; no matter what woman, from what background, or from what culture, religion, anything. Everyone should be treated equally, be given the same care, given the same sort of informed choice. Whether it happens or not is a different thing, you know … In practice I think it is getting towards that. To the woman's face it is but, sort of behind the scenes, midwives still say "That one there is a bit smelly", "That one there hasn't got a clue."'* (Frances, student)

Unlike in Case Sites A and C, such explicit critiques, even of the 'behind the scenes' attitudes and values of colleagues, were not in abundance. A major exception occurred within the focus group with post-registration students. Lucy felt that, in practice, many colleagues found it hard to keep their negative attitudes towards service users 'behind the scenes'. She felt that these attitudes affected their interaction with service users. For example, she mentioned the case of a drug user who was given a bad reputation immediately, instead of being understood by her midwife. She felt this kind of attitude was prolific amongst midwives and other professionals. Some other students in the group agreed. However, none of them drew attention to problems within their own practice in relation to issues of inequality, a discussion already begun in relation to Case Site A and returned to in Chapters 8 and 9.

Some respondents found it hard to define terms such as 'disadvantage' and 'inequality'. In common with many interviewees, Frances, a student, when articulating her understanding of inequalities, contradicted herself, seemingly without realising it. This may have been due in part to the difficulties inherent in responding to potentially complex questions 'on the spot' in interviews with a relative stranger. However, she seemed to define equality as sameness and the need for all women to receive the same care but went on to talk about the need to recognise difference.

Bridget, a senior educator, responded to the question about equality of care by emphasising the need to recognise different needs. She thought that equality of care was best thought of as *'a tension between giving everybody what they ask for'* and *'trying to be fair because some women don't know what they need because they have never had the chance to find out'*.

Bridget was one of few respondents who discussed equality of care in terms of clinical issues. She argued that women often needed to 'opt out' of particular clinical practices, implying that standard practice was interfering with delivering equality of care in some way. This also applied to students. She gave the example of a class she had run where she encouraged students to question standard clinical practice regarding the delivery of the placenta and membranes. She advised them:

> *'If you could suggest to them [qualified midwives] that you would like to deliver the placenta and membranes by conservative management …'*
> (Bridget, senior educator)

However, Bridget went on to say that the students claimed that they *'… wouldn't be allowed, because the policies state that you use active management'*. She had then pointed out that they needed to make it clear to the midwives that it was part of their learning to see this physiological process unmediated:

> *'One colleague had then made the comment that, "Well you would have to get consent to do that." I said, "Consent for not interfering with physiological process?" It is almost that the world has become turned upside down!'* (Bridget, senior educator)

Bridget referred to clinical issues again when discussing disadvantage. She made it clear that she did not comply with the dominant discourse that suggests more resources (here, technological resources) necessarily confer advantage:

> *'No doubt you will hear about the wonderful services that they have got [at specific hospital] and all the technology. I think the women who book at [hospital] are disadvantaged because they have got so much equipment, they have to justify it and use it. I think in [region] we are disadvantaged in maternity because we don't have many midwifery-orientated units where the midwives provide a conservative approach to care. So I see it the other way. It is not about what you've got, it is to do with approach and safety and confidence.'* (Bridget, senior educator)

Later, Bridget spoke again about clinical issues in relation to inequality and disadvantage:

> *'One thing I haven't mentioned actually is the inequality of the woman in relation to the foetus. Because I think that women are of secondary importance in the maternity services at the moment, in terms of funding for research they definitely are … There is not research funding for normal pregnancy and care. It is all about foetal issues, foetal medicine, chromosomes and all that, medically-orientated but diminishing the importance of what is going on with the woman … And also we are aware of the fact that the caesarean section rate is just going right up at [hospital]. We have got consultants in London who are saying things like "Women should be able to choose to have Caesarean sections." That is not choice, that. It is like everybody should be able to choose to have their appendix removed with no signs or symptoms. So I think the whole rhetoric around inequalities is actually being used against the people who are the victims of inequalities.'* (Bridget, senior educator)

Bridget thought feminist ideas were potentially important in midwifery. However, she felt that these could be 'turned inside out' and used against women in a similar way, particularly with respect to concepts like choice, which were used without regard to issues about information access and management.

Bridget's position, which was largely concerned with the way in which structural issues constrained choices, may be contrasted with that of Sharon, an educator colleague, who talked about how she taught students about the importance of informed choice. Sharon, placed great emphasis on the difference between giving advice and *'giving them the information and then supporting them in the decision that they actually make'*. Here, the midwife's role could be interpreted as being non-directive in relation to the rather complex issues of information interpretation and management. Her response is perhaps the more typical in the context of midwifery education, given its grounding in the liberal philosophies of individualised/woman-centred care. A further way of framing this would be to see Sharon's role as empowering women to make their own choices.

Bridget's position, in contrast to Sharon's, and all other educators interviewed at Case Site B, takes an anti-oppressive line more in keeping with some perspectives voiced in disciplines such as social work (Williams, 1999). The fact that she was an educator, and did not face the daily challenge of implementing AOP, might be seen as relevant. Of course, as one educator pointed out, educators need to take responsibility for implementing AOP in the university environment. However, Argyris (1993) points out that there is a difference between verbalising applicable knowledge and what the person does in practice. This may be relevant here since Bridget did not have the responsibility of implementing AOP as a midwife working with clients.

As suggested in Chapter 3, in other disciplines such as social work, commentators suggest that operationalising anti-oppressive agendas is difficult. However, in midwifery, the virtual absence of such debates, even at a conceptual, let alone operational, level is striking. One exception is the work of Neile (1997a; 1997b), discussed in Chapters 3 and 4. Considering there are so few voices expressing explicitly political ideas even in the educational context (traditionally a space for the exploration of ideas), it is hardly surprising that in the practice arena anti-oppressive debate is very rare indeed.

### 7.3.2 Knowledge, skills and attitudes needed for midwives to promote equality of care

As in Case Site A, from analysis of the interviews of managers, midwives, lecturers and students we were able to extract some of the types of knowledge, skills and attitudes that appeared to be needed if midwives were to promote equality of care to all women. The discussion here has the same headings as those employed in describing Case Site A:

- knowledge about the social/cultural context of women's lives
- understanding the nature and boundaries of the midwife's role
- attitudes and communication.

#### 7.3.2.1 Knowledge about the social/cultural context of women's lives

There was a clear consensus amongst community midwives that students could only gain knowledge and understanding about inequalities from practice placements in the community. Such experience was compared favourably with both classroom learning and experience from hospital placements. As a midwifery manager, argued:

> *'I think the community is a wonderful place to learn. Hospital midwifery is sanitised. Women come in, they are in our domain, in our environment. They do conform to some extent … they do behave in a different way to the way they behave at home. And I think, when you go out into some of those homes, as well, it shocks you … the food in the cupboard. And that is what the student needs to see. At the end of the day, it is dealing with women on a day to day basis, their worries, and headaches.'* (Peggy, midwifery manager)

There was no formal mechanism to ensure that hospital midwives gained post-registration experience in the community in this case site. Peggy, a midwifery manager, clearly wanted to address this by introducing a system of rotation, so convinced was she of the value of community-based experience. This concurs with Eraut et al.'s (1995) point that in order to fully understand and evaluate practice, practitioners must have experience in the full range of settings.

Further supporting the notion that hospital midwives do not always fully appreciate the social and cultural contexts of women's lives, a community midwife described what happened to her teenage mothers in hospital:

> *'We can do marvellous parentcraft stuff at [teenage mothers' project] and they feel safe and secure in the knowledge that this is going to happen and they are all wised up. Then they go on to delivery suite and somebody says, "What did your mum say when you got pregnant?" and "Oh, only 14, it must be hard". Really sort of patronising remarks, and everything that you have built up steadily just crumbles. They go back to being a child instead of "I'm going to be a mother in half an hour." … and I'm not talking about midwives that have been cruel, but they have just missed the point and have shattered this girl's built up esteem. They come out and they are different.'* (Clare, community midwife)

Here, Clare clearly expressed her desire to protect the young women from possible prejudice and the patronising attitudes of other midwives. Backing up her views on how some women might be treated, Jane, a midwifery manager, spoke of her concerns that hospital midwives had less positive attitudes towards disadvantaged service users and sometimes little understanding of inequality issues. However she was optimistic that the recent merger of acute and community services would provide scope to change this.

Clare's sentiments regarding younger mothers concur with those expressed by midwives in Case Site A. In both case sites they are an empirical illustration of the fears expressed by Baker (1999), who is concerned that negative attitudes to young mothers may be encouraged, rather than challenged by current Government policy which aims to reduce teenage pregnancies in Britain (Social Exclusion Unit, 1999).

It is interesting to note that Claire's proposed solution was to suggest that community midwives accompany women into hospital for deliveries, rather than that her colleagues on the labour ward were challenged on their attitudes. She advocated greater continuity of care, with community midwives doing deliveries as well as ante-natal and post-natal care. Pat, another community midwife, talked about being able to do that through the discretion she had to offer a small number of domino deliveries.

The view of community midwives being more aware and, therefore, more prepared to meet the needs of disadvantaged service users without judgement, was borne out by the account given by Sally, a service user. An 18-year-old woman with an eight-month-old son, Sally had spent much of her youth in care and in a secure unit for young offenders. She had a history of drug use and had been involved in theft to support her habit. She was aware that she was being assessed by social workers for her ability to take care of her son and felt some bitterness. On the whole, she found the community midwives helpful and non-judgemental but her experience of hospital midwives was rather different. Sally was asked what she would have liked in the way of support:

> **Sally:** *'... they were all OK with me, apart from the [hospital] crew.'*
>
> **Interviewer:** *'So it was in the hospital?'*
>
> **S:** *'It was the hospital I didn't like when they were all staring at us.
> When you go into maternity there is like a reception and all the midwives
> are sitting round gawping at you.'*

Cynthia, a woman with three children, also spoke about hospital and community midwives in very different terms. Pat had been her community midwife for her first two babies, now aged nine and two and Jo was her community midwife for her most recent baby, who was seven weeks old. Her description of her experience in hospital suggests that she felt she had received little caring and support and was made to feel too demanding. In contrast, she spoke highly of the care given by the community midwives.

The issues brought up by both midwives and service users in Case Site B in relation to the differences between hospital and community midwifery were mirrored in Case Site A. In Case Site C there were few such comparisons by service users; this could be because many received very fragmented care and did not develop a relationship with a particular community midwife. This is explored in Chapter 8.

The importance of students experiencing community midwifery in order to gain wide social and economic knowledge was brought home by Clare, a community midwife, talking about how students cope when first entering the community, especially where there was social deprivation. She remarked that they were often quite shocked by what they saw, and suggested that part of the problem here was the 'rose coloured world' of pregnancy and childbirth presented in the classroom. Classroom observations and student interview data did not bear out Clare's perceptions; indeed students received accurate and vivid representations of inequalities.

137

For example lecturers showed documentaries relating to issues such as domestic violence, health inequalities and gender issues.

Monica, a student who had been preceptored by Clare for the three-year duration of her programme, clearly valued her opportunity to work in a deprived area. She did not feel that much of her learning about inequalities came from the classroom, and expressed the view that working with a range of disadvantaged service users gave her an advantage over some colleagues who had never experienced particular client groups.

With respect to the needs of the Bangladeshi community, the interview with Nanda, a maternity link worker, was very instructive. Nanda acted as a link between health professionals and service users; she was responsible for translation and interpretation and worked with women ante-natally, during the birth and post-natally. Nanda mentioned several issues about which midwives should be better informed when dealing with Bangladeshi women. These related to understanding why such women might not attend parentcraft classes, the significance and implications of fasting, and the cultural emphasis placed on rest and separation from the baby in the days after birth. Here a more extensive knowledge about Muslim culture and rituals would enable midwives and other health professionals to be more sensitive to the needs of Muslim women.

Regarding the issue of rest after the birth, which involves separation from the baby, Nanda felt that her clients required more understanding and respect from health professionals. However, she felt that knowledge and respect for this practice was gradually increasing. This was reinforced in the interview with Madhur, a service user. Comparing the experience of her second baby's birth with that of the first Madhur said that her stay in hospital the second time was much better because the midwives took the baby, fed him and allowed her to rest for four days. However, it should be borne in mind that many midwives might consider this practice to be outside their remit. Others, influenced by Western childcare experts might justify their practice according to the dominant notion that it is harmful to separate babies from their mothers so soon after birth (Leach, 1983).

This point is interesting in the context of thinking about cultural difference, theories of childrearing and attachment, and the delivery of individualised midwifery care. On the one hand, midwifery can be seen to be at the forefront of designing services in response to user input, *Changing Childbirth* being a good case in point (DoH, 1993). However, such responses have often not sufficiently taken account of the multicultural nature of modern Britain. Here, the concept of 'cultural safety', explored in Chapter 3, is relevant. Were changes in midwifery policy and practice to be subject to the kind of cultural safety checks purported to be in place in New Zealand, it would be more difficult for practices not in keeping with people's cultural norms to occur.

However, it would be easy to assume that all Bangladeshi women feel the same as Madhur, just as all white, Western women are assumed to agree with the current practice of keeping babies with their mothers at all times. An account from Sally, a service user, suggests that this is not always the case. Sally had felt she needed a break from the baby and to visit the canteen, and had felt criticised by the midwives. Awareness of and respect for cultural differences is needed, together with recognition that there will be variation within cultures and that sub-cultural practices may also need to be understood and respected at times.

Midwives also need to consider their own attitudes to different practices. In Case Sites A and B there was considerable uniformity in midwives' cultural backgrounds. In Case Site C, cultural diversity amongst staff caused tension and impacted on client care in both negative and positive ways. These issues are explored in Chapter 8.

When probed on her attitudes towards issues of inequality, Bonnie, an educator, made the point that knowledge of different social and cultural backgrounds does not always, and perhaps should not always, lead to acceptance of certain practices. In discussing how she would deal with such experiences or help students deal with them, she was clear that part of the answer was to express one's feelings and to try to understand why one might feel that way. This degree of self-reflection was unusual amongst interviewees, although it was shared by a community midwife. Reflecting on her role, she talked about her own limitations in dealing with men, particularly from Asian cultures. She explained that she found the way in which she saw women being treated by the men in their families difficult to deal with. She was quite reflective about this and had clearly decided to limit her role to dealing with the women only, and not to take on what she saw as traditions that were centuries old:

> *'I try to deal with the woman and I ignore the man. I realise that it is her life. I can't insist on her doing anything that I say, she has to live with that man. She might not be happy but at this moment in time that is her role to be his woman.'* (Clare, community midwife)

Clare went on to say that she tried to be fair and understand these differences. When asked how she developed these skills and abilities, replied:

> *'I think some midwives can't cope with certain – I can't cope with Asian men very well. I just think "How dare you do this to this woman?" So I have to be very careful when there are men. I try to be as polite as possible. I keep saying to myself, my role is for this woman. I think that is my problem, I know that.'* (Clare, community midwife)

This is an interesting extract to analyse in the context of thinking about how midwives learn about, and challenge, inequalities. Clare clearly recognised her own unease with Asian men and the way they interacted with their female partners. However, she tended to understand her reactions solely in terms of not being able to deal with differences of tradition and culture, rather than reflecting that she might have stereotypical notions of them which affect how she related to some service users.

This extract brings us back to the wider debate concerning midwives' responsibilities and the midwife's role. For example, if domestic violence was suspected, would the midwife have a responsibility to raise the issue or would it be legitimate to leave it unchallenged, in the context of respect for cultural difference? RCM guidelines clearly state that all women should be asked whether they have concerns about domestic violence, thereby acknowledging anybody could be at risk, rather than making assumptions and using stereotyping (RCM, 1997). The practice of asking all clients 'difficult' questions occurs in other parts of this report and is relevant to other issues such as HIV, hepatitis C and same-sex partners (Mercey, 1998; Simpson et al., 1998; Wilton, 1996).

In neither Clare nor Bonnie's reflections above did they suggest that students should have a non-judgemental approach. Bonnie considered it important to consider and understand the origins of one's disquiet with a particular issue. The notion of being non-judgemental was frequently espoused in all case sites, and appears to be put forward as desirable and achievable by educators on midwifery programmes across England. However, the concept is not without problems and is revisited in Chapter 9.

### 7.3.2.2 Understanding the nature and boundaries of the midwife's role

Evidence from this case site supports the view that midwives, lecturers and students felt that midwives had a responsibility towards disadvantaged service users. However, there was considerable variation in the manner in which such work was perceived and undertaken. Some respondents clearly stated that midwives had a responsibility to all service users, others felt they had particular responsibilities to those they perceived as disadvantaged. It was clear that a further minority of midwives had developed specialist roles with a certain group. In this case site, such work was almost invariably connected with younger mothers. Clare's role, as a community midwife running a drop-in for younger mothers is a good example of this.

139

For midwives without such a specialist brief, maintaining professional focus and motivation in the face of service users who were perceived not to change their behaviour for the better was clearly an issue. Continuing to work with, and care for service users who do not act in ways health professionals would like them to is a theme in the literature (Brechin et al., 1998). Pearce (1989) has argued that where such work does not proceed in the manner in which the professionals would like, there is a danger that the difficulties are explained away by seeing the 'other' as mad, bad, sick or just wrong. Brechin et al. elaborate on this, suggesting that the carer will construct the service user through a process of 'de-valued difference':

> *'Constructing a de-valued difference can also be a way of shoring up a wakened self-esteem at the expense of the other person. The more someone is seen as particularly difficult, disabled, or challenging, the more acceptable it becomes for the carer to feel unable to cope. Locating the problem in the form of de-valued difference, more firmly in the individual, shifts some of the burden of responsibility from the carer. If one examines care relationships, care environments, caring roles, it is easy to see how many factors can threaten the carer's identity. It is also easy to see how a process of constructing a de-valued difference (or accentuating, elaborating, generalising from difference) can protect or shore up the threatened identity.'* (Brechin et al., 1998: 183)

A community midwife, talked at length about the frustrations of working with women and families for whom there never seemed to be any long-term improvement:

> *'Things like parentcraft – we do try and encourage it. You give them all this information and if they don't take that up I don't know what else you can do. You cannot forcibly bring them along and say you will sit there and we will talk to you.'* (Jo, community midwife)

Despite the frustrations, however, Jo was clear that midwives had a responsibility to address issues of inequality in their practice. She talked about that responsibility and the difficulty of setting limits to the role:

> *'I think there is a limit. Yes you can put in all these resources. The girl I was particularly talking about we put in all these resources … she was doing really well and then post-natally … everything looked really good and about four months later I found out she had left the baby with her mother for one weekend and she never went back. And you think all of that and obviously we know she's back on drugs again. Her relationship split up, he ended up in prison. She was absolutely lovely and, all that input, you just think everyone continued the support, I pulled out but the health visitor continued, so what changed I don't know.'* (Jo, community midwife)

Jo went on to further reflect on the nature of her involvement with clients, comparing how she dealt with clients who did not attend with how her colleagues did:

> *'I had this out with one of the consultants not long ago asking how long are we supposed to go and keep this up. He was saying, quite reasonably, "You can go twice and then say 'Right, if they are not prepared to come for their booking …'" I think most of us, I must admit, keep on trying. You can have women up to 28-30 weeks who you still haven't booked. Sometimes there is something in you that makes you think "I'm determined to get her!" Sometimes you could just scream. The consultants had no idea that we were spending as much time as this. Maybe there should be a point where you draw the line and think "Well, what are the midwives' rights here?"'* (Jo, community midwife)

Jo's thoughts are a good illustration of the dilemma between doing one's utmost to care for clients appropriately, whilst also taking care of oneself. Furthermore, this example highlights the variation in approach taken by some of her colleagues; in this case professional identity and gender seem important in determining how individuals react to their clients. Jo's extract highlights the difference between the role of the consultant who, seemingly detached from the lives of service users, 'had no idea' that Jo and her colleagues were spending so much time trying to access her client. This situation gives the impression that midwives, who are predominantly female, undertake the emotional labour in relation to interaction/attempted interaction with disadvantaged service users (Smith, 1992).

Kirkham suggests that the gendered nature of midwifery is such that its culture *'emphasises and internalises the values of caring and commitment irrespective of personal sacrifice.'* (Kirkham, 2000: 732).

However, one might ask whether Brechin et al.'s (1998) point concerning the construction of 'de-valued difference' is also relevant here. Jo's insistence that she is *'determined to get her [client to attend]'* may be seen as over-controlling, although midwives can justify such actions in relation to their Code of Practice. Given the discussion earlier regarding the potential surveillance role of health professionals and its negative impact on care, in such cases, it is imperative that health professionals self-reflect regarding their motivations for pursuing particular service users.

In this case site, only a minority of midwives gave a clear sense that they put definite limits on their roles. All the midwives drew attention to a lack of resources and personal burnout issues. Participants in the post-registration student focus group agreed that expectations on midwives to fulfil numerous roles were inappropriate. One lamented that if midwives were not careful they would end up being social worker, health visitor, relate counsellor etc. In one teaching session, the lecturer suggested that midwives were increasingly expected to be obstetricians. It was particularly striking that no midwife made the point that clients' privacy and choice not to conform to standard care delivery might be an acceptable reason for non-intervention.

Concerns regarding the limits of the midwife's role are, in many ways, connected to the degree to which midwives work with other professionals. Clare and Jo, both community midwives who worked alongside health visitors and rights workers, talked about the importance of good multiprofessional teamworking in order for midwives to meet service users' needs. For Jo, the time it took to build up sustained relationships with other professionals was a key issue:

> *'I feel that I'm quite established in the surgery that I'm working in and I feel that you really get to know everyone. After the five years that I've been there I know the families … Even just like building relationships with health visitors and GPs takes a long time and there is often a lot of shifting, even reception staff. They see a lot of people coming and going and I think it takes a while to become established. Even things like getting invited to meetings takes a lot of "Don't forget the midwife" … With other contacts like social workers, it's just a minefield really. Things like child protection meetings and conferences and what have you … It makes a difference if you know them well.'* (Jo, community midwife)

Clare and Jo had a clear vision of the need to work in partnership with other professionals. This model can be contrasted to Case Site C, where extreme constellations of disadvantage and grossly under-resourced services meant that participants spoke of work with other professionals primarily as referrals. In such cases, following up referred clients was often seen as impossible due to time and resource constraints.

This finding, which endorses multiprofessional teamwork is interesting in the light of educational provision at Case Site B. There was little evidence of shared teaching and learning,

141

apart from four early modules shared with nurses. Multiprofessional teaching and learning gives students experience of multiprofessional interaction and it could be argued that this is a valuable precursor to working in teams. However, shared teaching and learning was largely unpopular with students, who experienced multiprofessional teamwork through practice placements.

As in Case Site A, discussions concerning the midwife's role centred on its potential limitations as well as the issue of multiprofessional teamworking. This discussion is taken further in Chapter 8.

#### 7.3.2.3 Attitudes and communication

In interviews, midwives, students and lecturers did make references to attitudes and communication skills. However, in the case of service users this was an issue that was invariably flagged up as being of utmost importance. Becky, a mother of four, had some interesting things to say about the importance of good communication. Her account of her midwifery care during her last pregnancy suggested that she did not receive the care she needed and wanted. Her account suggests that the midwives were busy and that it was therefore convenient for them to assume that, as she was having her fourth child, she really did not need a great deal of input. However, Becky felt that things had changed since she had had her third child and she needed information and advice. She started by talking about her experience during the post-natal period:

> **Interviewer:** *'What happened when you got home? What kind of midwifery, post-natal care did you get?'*
>
> **Becky:** *'I came home on the Sunday. Nobody came out until the Tuesday. She rang on the Monday to say she would be very busy. She said if I had any worries or troubles she would call back out. She didn't do the full 10 days, I think out of them, she was only here for three. She checked [baby] was well, she checked that I was well. She just said "if there are any problems you know where we are."'*
>
> I: *'What do you think of that?'*
>
> B: *'... after such a gap, after having [third baby], it is like, a case of "Am I still doing things right?" Like feeding and checking his belly button and things like that. "Is he too hot, or too cold?" It's all changed. You can't lie them on their front, or their side. It has to be on the back.'*

Becky was asked what she might have wanted from midwives that she did not receive. Again, she articulated quite clearly that she felt she needed more attention and that, despite being on to her fourth pregnancy, she still had vulnerabilities and areas of doubt that she would like to have shared. Later, the interviewer asked:

> **Interviewer:** *'Anything else, any other tips or advice how midwives could be educated?'*
>
> **Becky:** *'I would say get to know your people better. Get to know your patients better because I find that if you know somebody a little bit, more than a couple of visits here and there, they will open up to you. Therefore more problems will be found out a great deal sooner than having to deal with a major problem after.'*

The above quote demonstrates the importance of continuity for Becky in her relationships with midwives. Becky later talked about a community midwife she had in previous pregnancies, and further articulated what she meant by good communication. Her community midwife for her latest baby was Pat but she saw little of her, having the majority of ante-natal checks at the hospital and consulting her GP for other matters. In contrast, her account suggests she built up a good relationship with Sheila, her community midwife during previous pregnancies:

142

> *'Sheila could come in and I would say, "Do you want a cup of coffee?" and she would say "I haven't got time." Then she'd say "Oh bugger it, go on." I mean she would sit down and she would make time. She was brilliant. You could talk to her about anything. She didn't make you feel that she was rushing to go somewhere else or promising to come next time and then not. She was always genuine. She wouldn't say one thing and then not do it.'* (Becky, service user)

Some of the issues raised by Eleanor, a 17-year-old mother with a six-month-old daughter, who spoke about the need for midwives to be friendly and supportive, concurred with the issues raised by Becky. When asked what she might teach midwives about how to treat women like herself, she replied *'Just to treat younger people with respect'.* She then referred to being left with her mother in the labour room for four hours without being checked by a midwife, which she thought may have been related to her youth. Mabel, who became pregnant at 15 and moved to a school for pregnant young women, felt very aware of the possible prejudice she might receive. Having had a bad experience with a GP who had written derogatively about teenage schoolgirls in a letter about Mabel to the hospital, she was clearly wary about going into hospital.

Another young mother, Vanessa, aged 19, with a six-month-old daughter, spoke highly of Clare, the community midwife, and of Clare's work at the teenage mum's group. Vanessa felt it was possible to talk and get advice, although she also said that sometimes there were not enough opportunities for one-to-one discussion with the midwives and other support workers.

Rosie, a mother of two young sons, also talked at length about the importance of good communication skills in midwifery. Rosie had a history of problems in pregnancy, due to a chromosomal abnormality, and had had several pregnancies before having her first son. Her second son had experienced trauma during birth and longer-term effects of this were still an unknown entity. She spoke very highly of Jo, her community midwife:

> *'My community midwife was fantastic, she came to see me in hospital nearly every day ... It was great to see her, somebody I knew ... She was there all the time.'* (Rosie, service user)

It is significant that Rosie had known Jo for five to six years and that Jo, therefore, knew her history of complications. Continuity of care issue is clearly relevant in cases like Rosie's where a good understanding of past pregnancies can help midwives to understand women's reactions to subsequent ones.

Rosie was asked what qualities made Jo a good midwife. She felt that in contrast to some of her previous midwives Jo always had time, engaged with her partner and her other child, was warm and friendly and:

> *'... a great listener ... She doesn't ignore what you say and she doesn't just talk over the top of you. I think that is a very important quality for a midwife.'* (Rosie, service user)

For Rosie, good communication clearly involves taking a real interest, both in the woman and her family, and being a good listener. Good communication was also important for Martha, an 18-year-old woman with a four-week-old daughter. Her daughter was born without a foot on one leg, a disability that Martha had learnt about when she was seven months pregnant. She spoke highly of the midwives who tried to prepare her for any shock she might feel at the birth, although she admits that she still felt very panicked:

> *'The midwives, they were dead supportive. They gave us a number and said "Anytime you want anything phone" and they will come straight out. I think [names], they gave us a good talking to and told us everything*

143

> *about it and said "Don't worry about it." Even though I was ready for it I wasn't really ready for it in the end because when she was born it was just like a bit of string full of blood hanging from her leg. Like a bootie full of blood and bone. So at first I didn't want to see her. I didn't want her. That was only for a day. I was having panic attacks.'*
>
> (Martha, service user)

Martha compared these midwives' good communications skills with those of the woman who had performed the scan that identified the undeveloped foot. Martha explained how this woman had asked *'Do you want to get rid of her?'* This insensitivity to is reminiscent of the discussion in Case Site A regarding cleft palates.

Martha's baby was delivered by Clare, the community midwife who had also delivered Martha's mother's fifth baby two months before. Again, the importance of a known midwife whom Martha perceived to be 'like a friend' and of continuity of care comes out in Martha's account of her daughter's birth.

When asked about what kinds of things midwives should be taught to help them care for women in her situation, like many others, Martha felt it was important that midwives had time to chat, to understand people's problems. She felt they should *'Sit and have a chat with you and a cup of tea,'* and added *'I never really thought midwives could be as nice'.*

Previous research supports the notion that, midwifery service users value good communication skills highly (Hart et al., 1999). An ability to put clients at ease, smile, be friendly and explain things in a way that the service user understands are of paramount importance. Many midwifery programmes highlight communication skills as an important component of midwifery education. However, the extra challenges faced by midwives in working with clients who evoke uncomfortable feelings in them are, as Bonnie, an educator, suggests, issues which need exploring further. Even though midwives may have knowledge of a service user's cultural, social or economic background, they may not be able to respond to that client in a manner which demonstrates good communication skills. This may be because they have not sufficiently analysed their own reactions to such knowledge (Brechin, 2000).

This last point raises an interesting question about the balance of teaching on midwifery programmes. Should midwifery education on inequalities issues concentrate on providing knowledge about specific cultures and areas of social disadvantage or should the emphasis be on supporting students to develop the appropriate communications skills? Clearly, both are important and the latter may be impossible without the former.

### 7.3.3 Midwifery education re: inequalities and the delivery of equality of care

As in Case Site A, research at Case Site B sought to investigate educational provision. The discussion below follows the same format as that in Case Site A:

- teaching and learning about inequalities
- theory-practice links
- the importance of practice placements
- the importance of reflection
- the assessment of understanding of inequalities issues.

#### 7.3.3.1 Teaching and learning about inequalities

As in Case Site A, educators were largely of the opinion that inequalities issues permeated midwifery programmes, although some made the point that inequalities featured more prominently in some modules than others. For example, an educator explained:

> *'I think the initial units that I deal with in the beginning of the programme, looking at pregnancy, reproductive health in pregnancy [cover inequalities issues]. And there is a unit that [colleague] does which is mainly about health policy from a feminist perspective so she certainly brings to the students' attention the issues of inequality very strongly. I suppose what I do is I apply it to ante-natal care in the unit that I do. The other units like the unit on pain relief, I don't think it features so strongly. Then latterly the students have a triple unit which has a dissertation and the guidelines certainly lead them towards considering issues of inequality.'* (Sharon, educator)

Although she clearly recognised the importance of developing students' understandings of inequalities, a senior educator questioned the current balance of teaching on the programme, suggesting that issues such as physiology were under-explored:

> *'We have actually put a lot of emphasis on to social sciences etc. and we are actually considering reducing that substantially. Not because we don't think it is important but because we need to get a balance on what the midwives role is because we are not social workers and all. There are lots of medical issues that we need to spend a bit of time on.'*
> (Bridget, senior educator)

As in Case Site A, students expressed a number of views regarding teaching and learning about inequalities. Monica, a student towards the end of her degree programme, was quite negative about the formal learning she had received. In particular, she felt that the 'social policy' module in her first year was not relevant to midwifery, a comment that was made in Case Site A regarding sociology-based modules. Part of the problem, for Monica, as for other students, was that the module was a large one shared with student nurses and that midwifery issues were not drawn out sufficiently. However, as she readily admitted, whilst students had been so fed up at the time that they had sought to have the unit 'banned' for its irrelevance to midwifery, with hindsight, its relevance had become clearer:

> *'Once you get out there and you see and then you are bringing other units in and you are applying what you have learnt there, that is when it starts to come together. But at the time it seemed like a waste of time.'*
> (Monica, student)

Another student near the end of her programme was more positive about first year coverage of inequalities issues:

> *'I think it is important in the first year as well because that is when you are first starting out. I think they need to make you aware as soon as possible because you could go out there and make terrible mistakes.'*
> (Frances, student)

Asked if she thought anything was missing from the inequality sessions, Frances was clear in her response based on her need to know in order to deliver appropriate care:

> *'I think what I would have liked was more information on minority groups and religions and things … I haven't had to look after anyone Asian or Muslim and if I did I'm afraid I wouldn't know what to do. I would have to go for some help from somewhere. You can ask the woman but sometimes there are language barriers and things and I don't think we have touched on that very much … We have done loads on social class but I think on the minorities, we haven't done a lot on that.'* (Frances, student)

Caroline and Nicola, who were new to their programme, made similar points. Their interest in multicultural issues had led them to focus on this in their social policy module.

Nicola talked about how she had wanted to start by asking other students how they defined an ethnic minority in the context of this city. She was aware that, whilst she felt very much a minority as a woman from a white non-British cultural context, most of her fellow students would not see her this way because they would think of ethnic minorities as not being white.

The above students were clearly not united in their views regarding the placing and content of the social policy module. However, educators took students' perspectives on this matter seriously. During a feedback session, one lecturer said that the placing of this module was under review.

One popular way of helping students to understand the backgrounds of disadvantaged service users was the inclusion of user representatives in classroom teaching and learning. However, most participants agreed that there was not enough of this. The point that some disadvantaged groups might be more difficult to have represented than others was also relevant. For example, Monica, student, suggested that women from 'lower social classes' were unlikely to want, or feel able, to come and speak at a university. The speakers she remembered on her programme included a disabled woman and representatives of groups such as Women's Aid, a twins support group and the National Childbirth Trust, all of which would be more accustomed to doing such talks.

Another student talked about what she had gained from a talk by a disabled woman:

> *'It was brilliant because she could approach it from her point of view. All the stigma that she has had to overcome in her entire life … using the baby baths, she couldn't get her chair anywhere near the bath to bathe the baby. Things like that. So that was important to make you think.'*
> (Shona, student)

As well as being asked to reflect on the placing within the curriculum of inequalities issues, and enabling students to gain an understanding of user perspectives, participants were also asked about the specific content of inequalities sessions. Sharon, an educator, was asked if and how students were taught about local inequalities. Her response was vague, considering she had a prominent role in programme management and delivery, although she did mention that in one of her modules they tried to look at local trends in relation to infant feeding. A senior educator seemed surer of how local inequalities were used as illustrations:

> *'I think a lot of teachers … would use local statistics to try to demonstrate differences. We often start off setting the scene … For example, breastfeeding, we will look at the breastfeeding rate. We will say "Why is a women who lives in [poor area], why do only 10% of those breastfeed their babies whereas only a mile away in [affluent area] you've got 70% of women breastfeeding?"'* (Andrea, senior educator)

Another educator taught mainly post-registration students. When asked how inequalities issues were dealt with in her degree programme, she responded:

> *'We have separated to some extent those notions and put them in a unit called Health Policy where we specifically deal with issues of inequality and disadvantage etc.'* (Bonnie, educator)

However, Bonnie went on to say that inequalities issues come up in all modules. She gave the example of how a module addressing woman-focused care incorporated such a perspective. As part of this module, students had to implement a change in some aspect of their practice:

> *'So I would say [to a student], "If you are doing a practice change, how is that service that you are providing there going to be accessible for women who don't speak English as a first language etc., etc.?" I think we try and raise the questions but I have to say that dealing with qualified midwives*

> *often the answers are left a lot more with them then we would do with the pre-registration course.'* (Bonnie, educator)

Classroom analysis of one of the sessions on this module bore out Bonnie's claims that it encouraged students to think about the needs of a diverse range of service users. Student projects ranged from exploring the provision of care to younger mothers, through emotional support in the post-natal period, to tackling incontinence. The module also clearly encouraged students to think critically about issues such as choice and continuity, drawing on relevant and up to date literature from the midwifery field.

Despite some general scepticism about classroom learning, a community midwife spoke of her own post-registration education in very glowing terms, emphasising the depth and breadth of knowledge it offered and the ways in which it informed and changed her practice:

> *'The Child Protection course was great, it was really good. Even just meeting on the course, survivors of abuse and things. That was really interesting, how women then go on to have a pregnancy and how it can affect them so much ... Looking at women who are in labour who might be thought of as uncooperative women, and you think "Why is she like this?" and maybe somewhere along the line she has had a history of abuse ... I didn't just want to do the diploma points just for the sake of doing them, I wanted to get something out of it.'* (Jo, community midwife)

To some extent, post-registration learning related to inequalities issues also took place within the trust. Peggy, a midwifery manager, was asked about opportunities offered. With the exception of child protection she could not think of anything specific. Later she explained that the maternity unit offered education and training sessions but that these tended not to focus explicitly on inequalities. However, she gave examples of a relevant session offered by the health promotion department on learning difficulties, which one midwife had attended.

The issue of qualified midwives having the opportunity to attend study days has been raised in the midwifery literature. Questions concerning whether or not they must pay for their studies or whether programmes are paid for by their trust are clearly controversial. As in Case Site A, midwives seemed to have a clear entitlement to study leave. Asked about opportunities for attending study days, Peggy was unequivocal that the opportunities were there, but clearly felt the need to stress that there was a *'service to run'*, implying that education and training were extras.

A community midwife, seemed to concur that study days were not difficult to come by:

> *'The odd study days we do have to pay for, a lot you get time for, usually get time or the cost. The actual things for degrees and diplomas, usually because they are based in [city], they are paid for but we often have to do them in our own time. Officially we get 12 study hours a month as full-time workers ... but I don't mind using my own time.'* (Pat, community midwife)

### 7.3.3.2 Theory-practice links

Interviewees were, on the whole, positive about links between the midwifery service and the education provider. Formal meetings took place between the heads of midwifery education and services four times a year in which midwives' continuing educational development needs were discussed. One of the most frequently mentioned links were those established through clinical liaison, whereby university staff made regular visits to practice areas. Andrea, a senior educator, drew attention to the fact that although staff differed in how they arranged their links it gave them an opportunity to visit students and preceptors in practice.

Another senior educator did not appear as convinced as other participants regarding the degree of fit between university education and practice. She reflected that the classroom had become a 'bit of an ivory tower' and was asked to expand on this:

> *'Higher education is for people who have a determination to enter an academic life and I think really we need a few people in midwifery and nursing who are able to manipulate theories and produce research etc. But they are not more important than the people in the clinical area. It is getting communication between the two is what is important … because we are all in higher education now, we seem to have lost it. At one time the midwife teachers would be involved in policy-making in the trusts, write standards and things. But now everybody is outside of that, other than in the clinical link role. I am a bit confused about it all really.'*
>
> (Bridget, senior educator)

Bridget's confusion is reminiscent of the sentiments expressed in *Integrating Theory and Practice in Nursing* (NHSE, 1998), which identifies problems in relationships within, and between, sectors of the profession, that were thought to be exacerbated by the move into higher education. These problems were particularly difficult between those in practice and those in higher education.

As in Case Site A, there was a wide variation in the degree to which midwives were aware of what students were doing in the university context. One of the better-informed community midwives was preceptor Clare. When asked about her knowledge of, and links with, education, she seemed well informed and well integrated, including having been asked to talk to students in the classroom about the different cultural groups with whom she worked. She also mentioned that she looked at students' written work and discussed their assignments with them.

A senior educator described the difficulties students faced linking theory and practice. She felt that practices observed by students were not justifiable in terms of the evidence-base, but that students found it hard to challenge and were quick to conform. She went on to express the view that students' practice experiences shaped them in important ways, although these ways were not always in ways educators found acceptable:

> *'… hopefully we are producing midwives at the end who are very questioning and who will continue to ask questions. I don't know if we do. I think they very quickly learn to conform. Or to exist in the social order of the hospital. You can see from the written work and the way they respond in class, even though I know them all, you can still tell which hospital base they're at. They just regurgitate the philosophies of that particular care; they very quickly get socialised into what is acceptable.'*
>
> (Andrea, senior educator)

The above point raises the important issue of the degree to which students receive appropriate preceptorship in community and hospital settings. This complex issue is returned to in Chapters 8 and 9.

### 7.3.3.3 The importance of practice placements

As in Case Site A, practice placements in a variety of areas were perceived as important. However, this was not reflected in a specific policy that facilitated students working with a diverse range of service users. For example, a senior educator said:

> *'We do encourage them to move around but it's not unusual for a student to do all their community placement in the same area. In fact if they are asked to do something they often come in and say "I don't want to work with so and so …" That's something maybe we should make more formal*

***because there is a huge variety of communities that the students could experience and I think it's important that they do.'*** (Andrea, senior educator)

Sharon, an educator, agreed that more could be done in this area. However, when asked whether she thought such movement between areas should be compulsory she stated clearly that she did not think this was appropriate.

Peggy, a midwifery manager, was asked about how she allocated students to practice placements. She tended to try to place students near to where they lived, an approach that might limit their exposure to lifestyles and cultures different from their own. However, another way of looking at this practice is that it represents a student-friendly approach by taking into account such issues as lack of car ownership and financial hardship which reflects the parallel concept of family friendly working arrangements.

One potential solution to this issue of practice placements in specific areas was the initiative taken by two students who arranged their own swap between their community placement areas, one an affluent area and the other a deprived area. Bonnie, an educator, said that the students had been ***'absolutely amazed at the contrast between the groups'***, and when the students were interviewed this clearly came across. The manner in which these students took responsibility for their own learning is reminiscent of pre-registration student Priestley's attempts to arrange her own placement on recognition of a learning need in relation to working with ethnic minority clients (Priestley, 1997).

Researchers such as Kent et al. (1994) suggest that students' learning experiences are shaped by the type of midwifery services found in that area. The fact that students do not always have practice experience in specific areas was highlighted as problematic by Gerrish et al. (1996) in their study of nursing and midwifery students' preparation to work with ethnic minority service users.

The need for students to experience a range of practice placements has been clearly recognised in Case Sites A and B. However, given the understandable concerns of lecturers not to over-burden students, the issue of how to achieve this is complex, and is discussed further in Chapters 8 and 9.

#### 7.3.3.4 The importance of reflection

Students on pre-registration programmes were certainly introduced to the importance of reflection early in their preparation. One fieldworker observed a session near the beginning of the three-year programme in which they were introduced to theories of the self and given a framework to illustrate the importance of self-awareness. The session was clearly introductory and engaged the students in a non-threatening way. The lecturer suggested that this would be revisited later in the programme in relation to students' specific midwifery experiences. ,

However, although many respondents, especially midwives and lecturers, talked about the importance of reflection, only Bonnie really gave any detail on how she went about facilitating this reflection and the models used. She had been discussing attitudes and was asked how these were assessed in relation to her post-registration teaching:

> **Bonnie:** ***'They assess their own attitudes. We assess their learning from their attitude. If the student can reflect and produce some kind of evidence and learning from that then that's what is assessed, not their attitude. There is a model of attitude, development and change. I think it is Price, the model, that we use. If a student chose to look at their own attitude, and it is always going to be their choice to do that, we will never say to them focus on that. We might say to them, when they come with a critical incident, we might say, "Is this about your attitude to this woman?" and they might say, "Oh yes I hadn't thought about that. I was being such and such and I hadn't realised that I was being like that." So we would say to***

> *them, in terms of the development of that critical incident analysis, "Why don't you try applying Price more and look at, if you weren't changing your attitude, how were you protecting it?" "Well, I was protecting it because Price says this about the three point model so what I was doing was protecting this. I now realise that perhaps that is an aspect of my practice that I am going to deal with." So that is how I would assess it in relation to the analysis.'*
>
> **Interviewer:** *'What if they don't want to look at their attitude, you say you don't make them?'*
>
> **B:** *'The trouble is the unit that they are doing which is [unit], they can't avoid looking at themselves, it is just which theories they choose to use to do that.'*

Bonnie's teaching approach relied heavily on student reflection and debate about practice, especially, although not exclusively in a module dealing with interpersonal issues. Discussing the extent to which students needed personal experience of inequalities in order to have understanding and give appropriate care, Bonnie felt that it was helpful, and that students could learn a great deal from each other's experiences in. Bonnie was also one of the few lecturers who openly explained how she facilitated students' challenging each others' attitudes:

> *'I can think of things, like, recently we presented some theory about the nature of prejudice ... Within the discussion the midwives would say things like "I was down so and so the other day and I was dealing with this young pregnant girl. And I was really angry with her mother because I thought it's your fault that she is in that situation and you are perpetuating the disadvantage." You have it on a plate when a student does that. And another student would say "It is not her fault, it is a terrible way to be looking at it" and so the discussion goes on. So all you do is kind of light the match and then ... and that is how it works with the group of students that I have but I think we set it up to work like that.'*
>
> (Bonnie, educator)

Bonnie clearly saw herself as a facilitator of debates, rather than as a teacher with the authority to explicitly challenge students' attitudes. This point appears to be more widely applicable since, as in Case Site A, there was little indication in classroom observations of lecturers doing anything more than gently challenging student views. However, some lecturers informed the fieldworker that this was deliberate, particularly during the first year of pre-registration programmes. The difficult issue of how and when to challenge student views, as well as by whom is discussed further in Chapter 9.

Students themselves clearly recognised the importance of learning from their peers. Monica, nearing the end of her pre-registration midwifery programme, felt that she learnt more about inequalities through reflecting with colleagues informally than through formal lectures. Talking about the meaning of equality of care, she stressed that, for her, this was about the importance of being able to assess women's individual needs. She was then asked whether she was learning these skills on her programme:

> *'On my course, not really no, to be honest. You get a better understanding of women just by, I wouldn't say lectures, it is more who you are with, your peer group. Where I work is completely different to where somebody else works. Telling stories about different things you do, you think "Oh, I had never thought of it that way before." Using critical incidences. Looking at those, even over coffee. We do feed back a lot, outside of structured lectures and things.'* (Monica, student)

Monica's view was endorsed by Shona, another student nearing the end of her programme who also discussed the ways in which students learn from each other's experiences informally.

It is clear from this discussion of formal and informal reflection that students value an opportunity to think critically about their practice.

### 7.3.3.5 The assessment of understanding inequalities issues

Perhaps one of the more surprising findings of this case site analysis is that there appeared to be a huge amount of confusion about whether students were required to address inequalities issues in their assessed work and where and how this took place. This question was raised with preceptors, lecturers, midwifery managers and with students themselves. Many conflicting responses were given.

Peggy, a midwifery manager seemed not to know the extent to which students were required to address inequalities issues in either theoretical or practical assessments. This would seem surprising given what she said earlier about the close links between the education and service sides. Answering specifically whether or not students were assessed on inequalities issues in practical assessments, an area about which she could be expected to have greater knowledge given her current role, Peggy responded:

> *'Again I am not certain of that. You may have to get that information from the community midwives themselves, the assessors.'*
>
> (Peggy, midwifery manager)

Peggy did not perceive it to be within her remit to know about such issues. In contrast, other midwives seemed to be more informed. Community midwives, Clare and Jo, talked positively about education-service links. Both said that they met the liaison lecturer on a monthly basis and could call her whenever they needed to check assessment regulations or other issues regarding their mentoring role.

Janet, a community midwife, also seemed to have a good relationship with the link lecturer and described her own role in the assessment of students. She also made it clear that she regularly discussed students' progress with the link lecturer.

A senior educator was asked about how students' understandings of inequalities issues were assessed; her response suggests that it was not compulsory to address such issues:

> *'There are statements in the clinical competency booklet to do with meeting individual needs and addressing local population needs. In the university assessments we have these taped assessments which make up 50% of the award that students get. They are very focused on clinical practice and there is opportunity within there (pause), in fact the students who do well and get good marks usually do address issues to do with the local population.'* (Andrea, senior educator)

There seems to be some confusion. Students were not required to cover inequalities issues; it was their choice. However, Andrea suggested they would receive better marks if they did. Bridget, another senior educator, also responded vaguely when asked whether inequalities issues were covered in theoretical assessments. It would be understandable then if students were confused about what was required in such an assessment. Clarity of assessment task is important not just in terms of students' ability to achieve success but also because it sends messages about what is thought important enough to assess (Miller and Parlett, 1974).

In contrast to most respondents, Sharon, an educator, was clearer on this issue and stated that students on the 18-month programme were not required to cover inequalities issues in theoretical assessments:

> **Interviewer:** *'So they have a broad background in sociological issues around inequalities. Can I ask you about the student's theoretical assessments. Do they have to do something on inequalities in their assessments at some time?'*
>
> **Sharon:** *'No, nothing specific.'*
>
> I: *'Do they sometimes choose that [inequalities issue] even though they don't have to?'*
>
> S: *'Rarely.'*
>
> I: *'What sort of things do they do?'*
>
> S: *'It might be something as broad as access to ante-natal care or in relation to parentcraft and that might bring in the inequality of access and so on there. To be honest it doesn't feature very much at all.'*
>
> I: *'Why do you think that is?'*
>
> S: *'I think from students it isn't perceived as being interesting and their focus is on practising as a midwife and they tend to want to focus in, and perhaps our guidelines leads them that way, on practice issues.'*

At times, Sharon's response suggests that she saw clinical issues as separate and separable from inequalities issues. This point was pursued by the interviewer:

> **Interviewer:** *'By practice do you mean clinical?'*
>
> **Sharon:** *'Yes, I think that's why they are here and that is what they see as their focus. These students, of course, are registered nurses so we make an assumption as well that they have had some background on their Project 2000, which often they haven't had. So perhaps they feel that because we don't address it as a specific issue that they are out of their depth anyway.'*

There is a real tension in Sharon's responses, concerning the extent to which inequalities issues are important and how they can best be incorporated into the already stretched curriculum. At one point, this seemed to be resolved for her by her suggesting that the best way would be to *'have a specific unit on [inequalities]'*. However, moments later, she described the merits of her post-registration education and discussed how in one programme which was not explicitly related to inequalities, she looked into the issue of forced caesarean sections, an issue she clearly saw as related to inequalities:

> *'If you look at the women who have had forced caesarean section, not just here but in the States as well, predominantly they were women from ethnic minority groups. Access to things like IVF programmes. All things like that there are clear inequalities evident.'* (Sharon, educator)

Sharon seemed clear that clinical issues could also be inequalities issues, although this point was not developed. When it came to the assessment of practice placements, she believed that there was more of a requirement for students to look at inequalities issues, although, even here, the requirement was implicit.

Bonnie, another educator, gave examples of student work on inequalities in two modules she taught, one on woman-focused care and the other on inter-personal issues. Because the modules were for post-registration students, assignments were often related to practice developments. One example was of a student who developed a user-friendly leaflet for young mothers to be handed out in the ante-natal period.

Bonnie suggested that the post-registration students were required to include inequalities issues in their theoretical assessments:

> **Bonnie:** *'… they do look at issues to do with inequality and that. Then there are issues to do with gender inequality, with female sexuality and health. I think it is probably interspersed.'*
>
> **Interviewer:** *'And you would say that was compulsory?'*
>
> **B:** *'Yes.'*

However, in the context of the interview in which she was 'put on the spot', Bonnie was unable to specify examples of what and how theoretical issues were dealt with.

An innovation in assessment practice not found in the other case sites was the use of the taped assessment in which an educator from the university and a preceptor gave a joint oral assessment. The purpose of this was described by Andrea as to get students to link theory and practice in a more meaningful way than writing an essay:

> *'I try to encourage a dialogue between the student and assessor and the teacher about the particular topic. It doesn't always work that way because the assessors are often terrified to say anything in case they feel they are being assessed. The students who aren't particularly strong in oral skills might get a bit tongue tied and twisted.'* (Andrea, senior educator)

A student nearing the end of her midwifery programme described her experience of such a taped assessment:

> *'You have to go with an assessor from your practice and your tutor from the actual unit. You take an area, I did one on pregnancy and hypertension. I took a community midwife with me. You have to discuss the whole condition that you are looking at with relevant theory. You have to relate the theory to the practice. You have to talk it through, there is no sitting with notes. Everything you say is backed up with evidence. So it is quite hard. What I did with mine was I did [pregnancy induced hypertension] and then took it and related it to high risk groups. Then because I work in the community where I have a lot to do with teenagers, I identified them as a high risk group and looked at ante-natal care. I looked at what society says about teenage pregnancies, defaulters, concealed pregnancies and then just looked at how that was affecting how much PIH there was.'* (Monica, student)

As with lecturers, there seemed to be some difference of opinion among students about the centrality of inequalities issues in assessment. One said that you had to demonstrate an awareness of inequalities, since:

> *'You couldn't go through the whole course if you weren't aware that people didn't earn £25,000 a year and live in three-bedroomed detached houses. You wouldn't reach your competencies.'* (Student, discussion group)

However, Frances, another student nearing the end of her programme, believed that students were not required to address such issues in assessed work. She was asked about how inequalities issues were taught in the classroom and mentioned group discussions based on specific scenarios before saying that none of these were subject to compulsory assessment. However, Frances made the point that students could cover issues of inequality if they chose to. Shona, another student nearing the end of her programme, agreed that inequalities issues were optional in assessment, whilst another emphasised that she felt they were embedded in everything they did.

In summary, as in Case Site A, there was some confusion regarding the extent to which inequalities issues were addressed in both essays and practice assignments. The taped assessment was an innovation that attempted to bridge the theory-practice gap. However, there were no innovations that clearly demonstrated the compulsory assessment of inequalities issues in pre- or post-registration programmes.

## 7.4 Conclusion

This chapter explored the ways in which participants thought about issues of inequalities and disadvantage in Case Site B. Structural issues regarding socio-economic status and ethnicity were clearly important in framing responses, as were the ways in which health professionals reacted to the perceived needs of different clients. The type of knowledge, skills and attitudes midwives need to develop in order to care for disadvantaged women were considered. As in Case Site A, knowledge of women's social and cultural backgrounds, as well a clear sense of the role of the midwife in relation to tackling inequalities was emphasised.

The final section of the chapter specifically addressed educational provision in relation to issues of inequality. Inequalities issues permeated the curriculum to some extent in pre- and post-registration programmes. Issues that arose in the classroom and in practice were explored, and the issue of practice placements in areas with which students were unfamiliar was identified. Finally, the fact that, as in Case Site A, there was no clear imperative in this case site for pre-registration students to be assessed on issues of inequality was explored. The only compulsory assessment was on a post-registration core module where students were assessed on issues relating to gender.

## Key Points

- Case Site C was in an inner-city area with high levels of social deprivation and a large ethnic minority population. There was a medium-sized midwifery education department, and at the time of the research, both 18-month and three-year pre-registration midwifery education was available.
- Curriculum analysis revealed that the philosophy and aims strongly reflected the needs of locally diverse groups, with ethnicity and cultural issues threaded throughout.
- Every module but one, and every theoretical assignment but one, made specific reference to inequalities in health and/or health care provision.
- Uniquely to this case site, language was a key issue for the midwifery service, with approximately 80% of clients being from a range of ethnic minorities. Many respondents felt that language barriers presented a huge obstacle to the delivery of equality of care.
- The site had a bilingual health advocacy service, and many midwifery respondents recognised its importance. There were, however, tensions between midwives and health advocates, with some midwives doubting the reliability of translations. Advocates were aware of these concerns but saw their role as extending into the realm of empowering agent. Similar to Case Site B, the advocacy service was restricted to office hours.
- Individualised or woman-centred care was rarely mentioned. Instead, respondents talked about the constraints on equality of care, and several expressed frustration that this was rhetoric which did not exist in practice. These comments were unique to this case site.
- The site had a poor midwife-to-woman ratio, a large number of midwifery vacancies, and depended heavily on agency staff.
- In contrast to the other case sites, the ethnic mix amongst the midwives was considerable and it was suggested that the different midwifery cultural perspectives might be confusing for women, as there was the potential for conflicting advice. Students suggested that some midwives espoused their cultural and religious views in a manner that was oppressive for people who did not hold such views.
- Some service users expressed racist views about some midwives. Such comments were unique to this site.
- Women complained about poor support with breastfeeding, poor assistance with language difficulties, and impatience and rudeness of staff.
- Students felt that they had received considerable input on inequality issues, but that this may have been at the expense of basic knowledge such as physiology. This, again, was unique to this site.
- There was recognition that students required practice placements that would broaden their experience. However, managers reported having insufficient mentors to accommodate this, and students were concerned that they received inadequate support in placements.
- Midwives reported having a significant role in relation to referrals to other agencies, and one was concerned that she had become de-skilled as a midwife and had, instead, become a health advocate.

## 8.1 Introduction and background to Case Site C

The third case site was selected because of its high levels of socio-economic deprivation. It was an inner city area that was ethnically diverse and experienced considerable fluctuation as a result of refugees and asylum-seekers being housed in the area. The ethnic minority population of the area was 42%. The majority of service users (75-80%) did not speak English as a first language; there were approximately 37 core languages in use in the area.

Midwives, managers and students working in Case Site C clearly understood it to be an area of significant deprivation. In response to the question *'What do you understand by the term "disadvantaged?"'* one student replied *'This place, this place is disadvantaged'*. This kind of comment was common. There was a striking difference between this case site, where the majority of service users could be considered to be disadvantaged, and Case Site A, where midwives sometimes had to think very hard to identify disadvantaged clients.

The university in Case Site C provided midwifery education to several NHS trusts; the study focused on one of these. The trust and university were located in different parts of the city. The university was multi-sited and students attended lectures at several sites. The midwifery department comprised approximately 12 full-time equivalent educators; thus it was larger than Case Site A and smaller than Case Site B. Case Site C also differed from Case Sites A and B in that there was significant ethnic diversity amongst lecturers, whereas at the other sites staff members were predominantly white.

The programmes provided were an 18-month pre-registration programme and a fairly new three-year pre-registration programme. A new curriculum had recently been introduced which made use of 'problem-based learning'. Students interviewed individually at this case site were on the new 18-month curriculum, whilst those in the focus group were just about to complete the old 18-month curriculum. The university also provided many post-registration programmes. Some of the midwives interviewed had undertaken post-registration education at this university.

The students in the education department also reflected a degree of ethnic diversity, although the majority were Caucasian. One educator told us that they were actively seeking to recruit students from the local area, which included many ethnic minorities. Through the participant feedback mechanism, it was drawn to our attention that most students placed at the trust which formed the focus of the study, which served a diverse ethnic population, were from black ethnic minority groups, despite the majority of students being Caucasian.

Students undertook practice placements in two trusts, spending half their time in each. This provided the fairly unusual opportunity to experience two units and geographical areas. At the other case sites students worked only within one trust.

The trust which was the focus of the study, had a maternity unit with 4,000-4,500 births per annum. Lack of resources was a real issue here. Furthermore, the maternity unit experienced staff shortages and had problems recruiting. At the time of the research there was a vacancy rate of 7-15%. This necessitated the regular employment of agency midwives, particularly at night. Amongst the midwives employed by the trust approximately 60% were Afro-Caribbean, 15% Caucasian, 8% Chinese-Malaysian and 5% of Asian origin. This was very different to Case Sites A and B where staff were predominantly white.

The hospital-based services included an ante-natal clinic, a delivery suite, post-natal wards, a community midwifery-led unit and a base for community midwives. There was also a hospital-based advocacy service providing bilingual health advocates to all departments within the hospital between 9.00am and 5.00pm from Monday to Friday. It was not a maternity-dedicated service but the health advocates interviewed all reported that the ante-natal department was one of those in which they most commonly worked. The midwifery manager stated that it was policy for all non-English speaking clients to have an advocate present during the pregnancy booking session.

The ante-natal clinic was always busy and service users commonly reported waiting for several hours. The health advocacy service was hospital-based, and many clients who did not speak English were referred to the ante-natal clinic so that a health advocate could be present. This meant that they received very poor continuity of midwifery care, seeing a different midwife at each visit. None of the 10 non-English speaking women interviewed had developed a relationship with a particular midwife. Indeed, they had received a very fragmented pattern of care.

The community midwives worked in four teams, each covering a different geographical area. All areas had significant levels of disadvantage and all students undertaking placements within this trust encountered a variety of socio-economic deprivation. The number of community midwives had gradually depleted due to retirement and difficulty in recruiting replacements. The community midwifery manager reported that sometimes there were not enough midwives to act as preceptors.

Despite the many challenges to care provision at this site, it was obvious that there was strong midwifery leadership at managerial level, which focused on issues of inequality. Briony, a midwifery manager explained:

> *'From a trust point of view equality of care and equal access to care is extremely important, and I think that that is a well-recognised issue … We try and support staff by trying to do all sorts of different courses about diversity and caring for people equally and what that means and working some of those concepts through. We also have a very different ethnic mix in our midwifery staff than we do for the population we care for and it would be very naive of me if I didn't pick up that that causes friction sometimes, that is one of the things we have to work through. It is a very, very sensitive issue and if you look at some of the profiles of the midwives they have actually really pulled themselves up by their boots and come from very diverse and interesting and difficult backgrounds themselves sometimes … We have been working continuously about developing a culture, what it means for me to work in [trust], so that we have some common ground, "This is how we treat women." And that means some very basic work that we have had to do which is very difficult and sensitive at times.'* (Briony, midwifery manager)

This focus was reflected in the managerial commitment shown to the project. For example, the feedback session was well attended by midwives, managers, research midwives and health advocates. Furthermore, the points that emerged from the data, some of which were controversial, were reacted to in a positive manner and led to a constructive dialogue between different service providers. Local action points were also generated during this session, and it was clear that there was genuine energy and vision amongst the staff coupled with a clear commitment to improving the service.

During fieldwork for this case site, midwives, educators, students, managers and service users were interviewed. In addition to the prescribed interviews for each case site, five interviews were carried out with health advocates. Whereas in Case Sites A and B, all service user interviewees were referred by midwives, in Case Site C 10 of the 15 clients interviewed were referred via health advocates. These interviews were carried out with an advocate acting as translator/interpreter. Information sheets and consent forms were also translated into the appropriate language. Since it was only possible to do this with three languages, these were chosen to reflect languages spoken by different sectors of the local community.

By incorporating the health advocacy service, we were able to gain insight into the relationship between health advocates, midwives and other health professionals as well as into clients' perceptions of the midwifery services and health advocacy service.

## 8.2 Curriculum analysis of Case Site C

This section gives an overview of the specific ways in which inequalities in health/ disadvantage were addressed by the curriculum. Data sources for this analysis were the telephone interview completed by a senior educator at Case Site C, curriculum documents provided from the educational institution, and data collected during observation of teaching sessions.

The pre-registration programme about which the respondent chose to talk during the telephone interview was the former 18-month programme. However, a new modularised shortened honours degree for nurses had since been validated and recently commenced. In addition, a new three-year programme for non-nurses had started, using the same curriculum design. During her telephone interview, the senior educator explained the philosophical stance as reflecting locally diverse ethnic and religious groups and recognising women as individuals within the context of their particular environment. An example given from the old curriculum was that *'[Individual women's] societal and political environment need to be taken into account including their spiritual or cultural or religious beliefs'*. The respondent also talked of a vision of the midwife as a birth companion, who may challenge contemporary British models of midwifery practice, which may not be pertinent to new arrivals from other countries and some refugees. Other indirect examples of relevant statements were given such as *'open interagency collaboration'*, *'respect for the individual taking into account the client's hopes and aspirations'*.

An analysis of what was stated in the interview set against the new programme showed that attention to the needs of ethnic and religious groups remained a substantial influence on the curriculum. However advocacy was not specifically mentioned other than a reference to the concept of empowerment in the new curriculum. This was surprising given the fact that this was explicitly mentioned in the old curriculum.

Individual module aims in the new curriculum addressed social class and gender issues, e.g. *'Analyse the literature on contemporary sociology, social policy, feminist literature and gender impact on women in society'* and *'Examine midwifery history and those of dominant professions ... impact on today's legal framework, midwifery politics, funding and practice'*.

### 8.2.1 Main features of the pre-registration curriculum

The main features of the pre-registration curriculum at Case Site C can be summarised as follows:

- the curriculum design was based on Cultural and Situational Analysis models (Lawton, 1983; Skilbeck, 1984)
- content was organised into six units, all led by midwifery lecturers and exclusive to midwifery students; sharing occurred only between diploma and degree midwifery students
- several themes ran through the programme: applied biological and social sciences, health, ethics, and research; a theme of theories and philosophies of midwifery could be seen to run through the modules but was not made explicit within the programme description
- content was organised to move from 'normal' to 'abnormal' midwifery
- the document stated that students commenced their clinical experience at the beginning of the programme in a team midwifery environment in which they conducted a formative community/environmental study; they returned midway through the programme and again at the end
- for eight weeks at the end of the programme students were allocated a caseload
- elective placements could be taken either in other NHS trusts or other countries
- all students undertook practice experience in two different trusts.

### 8.2.2 Key findings of the analysis of pre-registration curriculum documentation

The key findings of the analysis of the pre-registration curriculum documentation at Case Site C can be summarised as follows:

- the flavour of the programme philosophy and aims strongly reflected the needs of locally diverse ethnic and religious groups and an individualised-care model; however, module aims more broadly included social class and gender issues and individual module content took these themes further by introducing domestic violence, social isolation and also consideration of mothers with special needs, e.g. disabled women and those who use drugs
- we identified all but one module in the new problem-based learning curriculum as having direct or indirect outcomes relating to inequalities in health and/or health care provision
- ethnicity and culture were issues that were threaded throughout the programme
- complex needs were interpreted to include users of drugs, teenage pregnancy and maternal disability, whereas domestic violence was addressed in the normal midwifery modules under social issues
- just one theoretical assignment made specific reference to inequalities in health and/or health care provision; the problem-based learning scenarios using triggers did include inequalities issues which were addressed in the compulsory written assignment, in this case domestic violence
- clinical practice outcomes did not explicitly address inequalities issues
- there was input on the programme from people representing different ethnic groups and a session challenging racial stereotypes
- all lecturers had attended study days on equal opportunities and the Disability Act.

### 8.2.3 Exemplar of a module addressing the issue of inequality

The module selected as an exemplar for Case Site C dealt with midwifery perspectives and values; it was shared by shortened degree and diploma students and taught in the first year. A module aim which was relevant to issues of inequality in health was to *'Analyse the literature on contemporary sociology, social policy, feminist literature and gender impact on women in society'*. This translated into the following outcome *'Understanding the concepts of power and the patriarchal structures for health care provision and how these affect women's choice and lifestyle'*. Content included gender issues, politics of health screening, race, culture and ethnicity, domestic violence, social isolation, inequalities in health, powerlessness and oppression. In the old curriculum this module challenged students to look at their value system in order to understand how they then approach other people. However, in the new curriculum this was not made explicit.

The module was assessed through an essay that related to trigger material used in the domestic violence session. An observed introductory session to domestic violence was thought-provoking. Students' thinking was broadened to include domestic violence victims in situations beyond those relating to able-bodied heterosexuals, by including lesbians and disabled people. Students were encouraged to explore myths associated with domestic violence and the session aimed to *'unravel our own assumptions'*. Student participation indicated that some were prepared to recognise themselves as potential victims of domestic violence. At the end of the session one student was visibly distressed and was comforted by the lecturer, who prioritised the need to offer support. This demonstrates the importance of recognising that students may identify with specific disadvantaged groups or may have had experiences which disadvantage them.

In this session, invited speakers from a community support group provided information about local resources. The midwifery lecturer contributed some practical tips, and graphic examples of abuse were used to stimulate discussion. A number of students contributed, despite large numbers and the lecture theatre venue.

A follow-up session providing the trigger for a problem-based learning approach was observed. A framework to encourage brainstorming and decision-making was used, facilitating the contribution of broad ranging ideas, but not allowing – within the sessions observed – time to explore the ideas fully or challenge the stereotypic views emerging. The concluding session which was not observed, where students gave their own presentations, may have provided a forum for this.

An unusual aspect of this module was that students were required to address an issue of inequality in their assessment. All students were required to write an assignment focusing on domestic violence.

It was clear from this curriculum analysis that, as in Case Sites A and B, there was significant coverage of issues of inequalities in the programmes at Case Site C, although its precise format and content varied.

## 8.3 Key themes and issues from the research data

This section explores the key themes and issues which arose from analysis of the interview and observation data from both educational and practice data sources in Case Site C. Table 8.1 summarises the data collated at Case Site C.

| Type of data | Description | Number | Duration (hours) |
|---|---|---|---|
| Interview | Focus group with midwifery students | 1 | 2 |
| | Interviews with midwifery students | 5 | 6 |
| | Interviews with preceptors | 6 | 9 |
| | Interviews with service users | 15 | 18 |
| | Interviews with midwifery service managers | 3 | 4 |
| | Interviews with midwifery tutors | 3 | 5 |
| | Health advocates | 5 | 7 |
| | **Subtotal** | **38** | **51** |
| Observation | Classroom observation | | 15 |
| | Practice observation | | 10 |
| | **Subtotal** | | **25** |
| **All data** | **Total** | | **76** |

Table 8.1: Data collated at Case Site C

### 8.3.1 Reflections on inequality and disadvantage

As in Case Sites A and B, lecturers, students and midwives were asked to reflect on the meaning of terms often associated with inequality and disadvantage and to say how they understood them in the midwifery context. In this case site, unlike in Case Sites A and B, language and ability to communicate effectively repeatedly came up as key to inequalities and disadvantage. With approximately 80% of their client group from a wide range of ethnic minority communities, staff and students felt that language barriers presented a huge obstacle to the delivery of equality of care. Despite the existence of a well-established bilingual advocacy service, there was general agreement that language remained a key issue for the midwifery services.

The findings here concur with those identified by Gerrish et al.'s (1996) study of the preparation of nurses and midwives to meet the needs of ethnic minority clients. The issue of language barriers arises in most discussions of the provision of midwifery care to ethnic minority clients (Kroll, 1990). Therefore, despite managers' good intentions and the existence of a bilingual advocacy service, advice such as that by Kroll (1990), in relation to the provision of care to minority ethnic clients, does not appear to have been followed. Given the enormous challenges faced by midwives in providing care to service users from such a wealth of cultural backgrounds within the constraints of the contemporary NHS, this is perhaps unsurprising.

The following discussion explores how informants framed their ideas on inequalities and disadvantage given that the issues of language and culture were so prominent. The following comment was typical of many participants:

> *'We don't think everyone gets equal access because if they can't speak the language how do you get the message across?'* (June, midwifery manager)

Whilst June acknowledged the importance of the health advocates, she felt strongly that there was insufficient support to meet the midwives' and clients' need for language support. In particular, the service operated only in office hours and the range of languages covered did not always keep up with demand.

Other midwives echoed this problem of access to the health advocates. For example, Iawa, a hospital midwife, praised their work but stressed the limited nature of the service both in terms of time and languages available. Rhoda, another midwifery manager, also mentioned the problem of the limited times in which the advocacy service was available to midwives. She stated that *'weekends are a problem'* since there was no advocacy cover then, and she went on to explain that at such times they had to rely on sign language.

The issue of advocacy also arose as an issue for community midwives. A community midwife explained how difficult it could be to have a woman in labour 'out of hours' who didn't speak English and be unable to access the advocacy service. She also made the point that having a 24-hour advocacy service would be *'wonderful'*. Regarding community visits she explained:

> *'For instance if I go to somebody's house today, and we don't often know that the person doesn't speak English until you get there. You can't communicate at all so you might phone from the house and ask for an advocate … and you can't get one until probably three days later. So you have to work blindly like that until you get an advocate.'*
> (Macy, community midwife)

As well as language, participants also made more general comments about issues of inequality and disadvantage. When asked about definitions of 'equality of care', responses varied. Managers tended to talk about how it could be ensured and other respondents were more likely to talk about the constraints on the delivery of such care. Rhoda, a midwifery manager, for example, felt that equality of care meant to give all women *'the same high standard of care'*. When asked how she ensured they received such care, she spoke about the auditing of notes, using feedback from service users and through the handling of complaints, suggesting that there was a real attempt to learn from, and build on, experience. Rhoda went on to talk about health improvement programmes that had been introduced in the last few years. These targeted deprived areas such as that of Case Site C. She gave a couple of examples of positive changes that had been introduced under these programmes. These were the development of the health advocacy service and the rotation of midwives between hospital and community.

When asked about how parent education was delivered to such a diverse client group, she responded by saying that 'standard' parent education was provided to everyone, although:

> *'Those people who don't speak the language we try to involve the health advocate to translate but, then again, it depends on their uptake because we find that some of the people from ethnic minorities don't come forward for parent education. Then you have to just pass on the information whenever you meet with them according to what you find.'*
> (Rhoda, midwifery manager)

The issue of attendance at parent education classes has arisen in all case site analyses. It is also the subject of some discussion in the midwifery literature (Collington, 1998b; Priestley, 1997). Findings from this case site regarding parent education raise interesting questions about how far commitment to meeting the needs of women goes when cultural differences become apparent. Also, the operationalising of the philosophy of individualised care begins to ring hollow when considered in this multicultural context. However, in this site it should be acknowledged that given the enormous range of cultural groups coupled with high levels of socio-economic deprivation, and seriously under-resourced maternity services, providing individualised parent education was a formidable challenge.

When shown the findings regarding parent education during the feedback session at Case Site C, midwifery managers said that the specialist provision of parent education to certain ethnic groups was receiving more attention. One example of this was classes provided in conjunction with a Bengali-speaking health advocate. However, this had not dramatically improved the uptake amongst Bengali service users. Another point raised at the feedback session was that Case Sites A and B had specialist provision for teenage parents whereas Case Site C did not. In response to this, it was felt that there was extensive provision for teenage parents by social services and other organisations in the geographical area. Manager Briony explained that when planning maternity care in such an environment of chronic under-resourcing, it was important not to duplicate services. However, the managers acknowledged that it would be worthwhile to liaise more closely with organisations providing specialist support to younger mothers.

Furthermore, it was pointed out that teenage mothers at Case Site C may have more support than those at A and B due to their ethnicity and family structure, e.g. they may be teenage but are married and living within an extended family.

A community midwife had some strong views on midwives' ability to deliver equality of care. When asked what this term meant to her, she answered categorically:

> *'Well this is where all the rhetoric comes in doesn't it? Very nice but not deliverable. Not even in any sort of shape at the moment.'*
> (Charlotte, community midwife)

A bilingual health advocate expressed a very similar sentiment. When asked what she understood by equality of care to all women, she replied:

> *'I think it sounds beautiful but the practice is not really there … Because if you are disadvantaged, by language for instance, and this is not being cared for properly you are not [receiving equal care] are you? So I would say on paper it looks very good.'* (Isabella, bilingual health advocate)

Isabella went on to stress that the commitment was there because there were *'very good people around'* who were *'all worried about it'*. For her, it was partly a matter of resources. Like others, she commented that the advocacy service was only 9.00am-5.00pm and therefore limited, especially in relation to women in labour.

One of Isabella's clients, Madelaina, talked of her experience of the advocacy service available to her during her pregnancy, labour and the post-natal period. Her experience was typical in that she had some access to a health advocate but also relied on her two older children to translate for her. In the hospital, the midwives were also able to call upon a doctor who spoke Madelaina's language. However, Madelaina told the fieldworker that she had not been aware that she could have visited her baby in the SCBU for the first three days, even though she had wanted to breastfeed him. This suggests that, despite the support available, there was insufficient attention given to communicating with Madelaina and her family regarding her rights and options.

Ellie, another service user, spoke of difficulties she had experienced during her pregnancy, especially in relation to language difficulties and the limited advocacy service. Ellie did not see any health professionals until she was about 20 weeks pregnant and was faced with a threatened miscarriage. She went to the accident and emergency department and was eventually seen by a doctor after a long wait. The interviewer asked Ellie how her ante-natal care progressed from there. She explained how, in a subsequent visit to the ante-natal clinic, she was sent away because the doctor said he did not speak her language. The following day she received a letter saying that she should take somebody with her who spoke English as they did not have an interpreter. Like Madelaina, Ellie relied on family and friends to interpret during this stressful time. Whilst she was very happy with her care overall and especially with the birth itself, she nevertheless felt dissatisfied with having to rely on family and friends in this way:

> **Ellie:** *'... because if I can't speak English it is not really me talking to the person or doctor. So if there is another person helping me, saying it for me ... If it is a proper interpreter then I know that this person is going to say everything that I said to them. But if it is a person helping me, only sometimes this person doesn't want to, or this person might feel shy to say something to me or to them.'*
>
> **Interviewer:** *'So if it is your sister-in-law or ...?'*
>
> **E:** *'Because sometimes she had one opinion about something that I was saying and I didn't agree or we didn't agree on the same point.'*

Ellie would clearly have benefited from having someone more independent of her family to translate for her so she could feel reassured that her feelings and preferences were communicated directly to the health professionals.

Lucia also had serious concerns about the care that she received from this same hospital. Language differences again meant she did not feel heard by the health professionals:

> *'I think it is the way they treat people. I do not always have somebody to go with me to the hospital. And when I go there, most of the time, I do not understand what the doctor is saying. And every time I go I tell them from the beginning that I do not understand very well and I ask them to please speak a bit slower or calmly, but it doesn't seem that they bother with this. They say what they have to say. I feel that they are telling me to go and learn English then come back and talk to them.'* (Lucia, service user)

Lucia had access to a health advocate on 'a few occasions', but like other women, she had to rely on more informal arrangements. During the birth, a cleaner, who spoke a language closely related to Lucia's, was called upon to interpret. Lucia found this distressing and kept asking for an interpreter but was told there were none available.

As well as language and communication, resource issues also persistently came up in relation to discussions about disadvantage. A community midwife felt that individualised care, in particular, was severely restricted:

> *'There isn't the capacity, whether it be time or funding or services available, to really identify what their true needs are. As midwives we are constantly frustrated about what we can't do within our own service,*

> *about providing the very basics of care, really basic … Well look, even like this morning, [community midwives] all assemble and there are two phones to use. So even with limited resources, it really has an impact on the delivery of care. I invariably end up trying to phone people at the social services in my own time.'* (Charlotte, community midwife)

A midwifery manager talked more generally about the huge problems faced by this trust because of the inadequate resources. The trust not only had a very poor midwife:client ratio but, unlike the other two case sites, was also unable to call on agency/bank midwives for day duty, as none were available.

Accounts from women themselves concerning their experience of care seem to support the contention that resource constraints were a major problem. Rosalyn's was one such account. Like several of the women interviewed, Rosalyn talked about her reluctance to go into hospital because she had seen how dirty the wards were. She described how she had wanted a water birth but had been told that it would only be possible if staff with the relevant experience were on duty. In the end, she was able to use a bath for a limited period. However, Rosalyn ended up having a caesarean section because of foetal distress and was left wondering if she might have been better off in the water for longer. Rosalyn was mostly philosophical about these experiences. Asked about her care on the post-natal ward she replied:

> *'They took my blood pressure, temperature and they gave me my injections, etc., all very well. Apart from that they were rushed off their feet. I was next to the nurses' station and one morning there was a massive argument between the ward manager and the sister/head midwife. They just didn't have the staff, one ward was closed anyway and they were just under so much pressure. I know how tough it is there.'* (Rosalyn, service user)

The thing that seemed to concerned Rosalyn most was the lack of support she had with breastfeeding, which she found surprising in a trust that was actively promoting this:

> *'I really wanted to breastfeed and there was very little help with that. And even when I had my drip in, when I had just come down, and obviously [baby] needed feeding, nobody passed me the bell. It was hanging down the back of the bed and I couldn't really move … I just had to make do myself. I know that when you are starting to help somebody to breastfeed it takes time but they didn't have the time. It was quite worrying because I really, really didn't want to give [baby] a bottle.'* (Rosalyn, service user)

Rosalyn was also quite distressed by what she witnessed in relation to the care of other women on her ward. As an English speaker, she considered herself relatively privileged, but was worried about other women:

> *'The woman in the bed opposite me was very ill, she was already a mother of eight. She was a Bengali lady, she had another by caesarean and then they found a big blood clot or something on the scar so they needed to remove it. When she came round she was obviously very ill and I would have thought that the midwives would have helped her to feed the baby, change her baby, but they didn't. They just shouted at her. The baby was crying and they came in and said "You can't leave your baby crying like that, do something about it." It just really shocked me, my mum did go over and help her.'* (Rosalyn, service user)

Of course, we do not know the perspectives of the clinical staff involved, but our purpose here is not to represent the clinical facts, but rather to document the client's perspective.

In reflecting further on the nature of disadvantage, several midwives talked about the type of disadvantages faced by their client group. Charlotte was one of the few who, rather than solely discussing the different needs of her clients, focused on the way in which midwives might compromise the provision of equality of care. Their own different cultural practices were, she felt, often confusing to the women in their care. This can be contrasted to Case Sites A and B where there was little cultural diversity amongst midwives. In Site C, according to Charlotte, women often received very different advice depending *'who was going in'*:

> *'You know, "You need to feed three hourly rather than on demand", or "You need to sterilise your bottles this way" or "Don't worry about it".'*
> (Charlotte, community midwife)

Charlotte clearly felt frustrated and disillusioned about midwifery and its ability to deliver equality of care. In a later discussion about inequalities in health in her area, she said that, with so many refugees, the issue was not about delivering different services to different groups but much more about the fact that *'day to day survival is different between different client groups'*. She outlined the types of problems faced by refugee groups and the particular experiences of pregnant women and new mothers:

> *'We have now got a lot of Albanian ladies, not in large numbers, but they find it difficult to work round the health care system. They deliver themselves at home. I have to say, they are probably far better to deliver themselves at home because at least they get the one-to-one uninterrupted care of a family member. Whereas if they come into hospital, they can't communicate effectively, the health advocates aren't available in the middle of the night, the midwife is carrying three labouring women. They go home, they can't access a GP, they can't access any food because they have to take their baby with them to wherever their docket place is ...'*
> (Charlotte, community midwife)

Charlotte also talked about the disadvantages faced by HIV positive women, whom she felt were unable to receive the care they or their babies needed because stigma often resulted in non-disclosure. Again, she emphasised that society should take collective responsibility for HIV, rather than individuals having to keep their status to themselves.

Ali, a specialist midwife, also talked about HIV in relation to inequality and disadvantage. She was reflecting on the introduction of HIV ante-natal screening in the trust and the fact that whilst leaflets were being sent to women prior to their booking interview, they were only printed in English. Leaflets in other languages were being prepared but there had been a long delay. Ali also talked about the difficulties of managing the care of a woman with a positive diagnosis for HIV when there was discontinuity in her care. Ali was then asked whether the midwives always had information about the HIV status of the women for whom they cared:

> *'The midwife who performed the test would, yes. It is possible that if she then doesn't see her again during the pregnancy, she may be seen by other midwives who don't know. We are trying to address that. Most women don't want anything written in the notes that they take home with them but I do write it in the buff folder.'* (Ali, specialist midwife)

This practice of not recording HIV status on the client's notes unless they requested it is in keeping with the RCM (1998) guidelines. Clearly the issue of confidentiality, necessitated by the stigma associated with HIV, can, and does at times, conflict with the needs of midwives to have full information in order to deliver appropriate care.

The ideas of students and educators regarding inequalities and disadvantage broadly concurred with midwives in the maternity services. Gayle, an educator, felt that in her practice link area there was an attempt to deliver equality of care although it was hindered by a lack of support services such as appropriate interpreters.

Students also seemed to have an understanding of equality of care that involved recognition of the constraints on, as well as the possibilities for, such delivery. Again, language came up as one of the most important issues. Students at Case Sites A and B also highlighted language as a problem and a potential root of inequality but for them it was the exception rather than the rule. In relation to Site C, a midwifery student provided an example of an inequality issue related to language:

> *'... the diabetic clinic, the leaflets are in English but there are none in any other language. I was looking into that recently and they have only just approved some sort of funding to actually look at giving out leaflets in another language. If you look at this, most people who are diabetic are people of the Asian community, 70% don't speak very good English. At the end of the day, yes, you can use advocates to tell them about it. But if they are anything like me, you tell me something in a consultation, I probably forget half of it. I will go home and read it, but they have nothing to take home to read.'* (Jodie, midwifery student)

Jodie also mentioned that the 'Language Line' service was available in theory but that *'you don't dare use it'* because managers said it was too expensive. This feeling was also reflected by students at Case Site A. In contrast to these students' views, some managers did flag up these services as areas where improvements in care provision could be made, and said they encouraged their use. When giving feedback on the draft of this report, Briony, a midwifery manager, suggested that the discouragement of such services may have been taking place at another level, that of senior practitioners on the ward, and that this was an issue that needed to be reflected on within the unit.

A focus group was conducted with students on the 18-month programme who were days away from completing their studies. Not all had undertaken a practice placement at the trust in this case site. Therefore, when reading the following extracts from this focus group, it should be borne in mind that students were not necessarily talking about this trust. One student drew attention to the fact that not only were their disadvantaged clients not given true informed choice, but:

> *'... also from the midwives' point of view, you're not necessarily equal to the doctors and they still override what should be a midwifery-led profession, and so it's like two categories of inequality. There's quite a lot of conflict.'* (Student 3, discussion group)

Thus the student drew attention to inequalities between professionals within the NHS, a subject already discussed in Case Site B.

Other students gave examples of where they thought equality of care from midwives was compromised, mentioning women from privileged socio-economic backgrounds and those from certain cultural groups were treated better than others. They also mentioned time constraints, suggesting that some service users needed longer than the standard 15 minutes for ante-natal clinics. Although the point was made that some hospitals had better staffing levels and received more funding than others, several students felt that midwives, as individuals, also greatly affected equality of care:

> Student 3: *'I've experienced midwives who've maybe been at their job a long time, they're a bit fed up with it and maybe they're not as keen to do that as we've been, or they're a bit downtrodden, understaffed ...'*
>
> Student 2: *'With those cases they don't prioritise any care so no one gets good care.'*
>
> Student 7: *'They get equal rubbish care.'*

> **Student 2:** *'Yeah, everybody gets it. Not just like white women get this or black women get this. It's just nobody gets informed choice.'*

Despite this assertion that everyone received 'equal rubbish care' it was apparent that most students believed that care given was clearly differentiated. In the group discussion, students discussed many cases they remembered in their practice placements:

> **Student 3:** *'We offer them the triple test in [trust in Case Site C] but that's not really as good as the nuchal fold. And that's just tough. If someone happens to know about nuchal fold, you might slip them over to the consultant, if they don't you just don't mention it.'*
>
> **Student 1:** *'I had a doctor once, and he was doing some research [another trust] that was going to be quite invasive and he couldn't really get any Caucasian people to volunteer for it. But I remember him with a couple of people who were Romanian, and couldn't speak English, and he certainly wasn't giving them informed choice and they were actually signing the form. I did say to him "I don't actually think they have any idea of..." So things like that.'*

This student reported being able to challenge the doctor. In data across the three case sites there were few cases where students said they felt able to challenge midwives or other health professionals.

Student 1 gave a recent example of her work within a specialist midwifery team, at one of the other trusts, providing care to a drug-using woman. She talked of a wealthy and well-educated heroin-using woman. The student felt that she was more accepted and got extra input, including a lot of consultant attention, in contrast to the more 'downtrodden' heroin-using clients who she felt were criticised and judged more. This suggests the relativity of certain inequalities, and how those with some social capital and status will be more tolerated by a system which may otherwise judge them more harshly.

Another student had two nine-month placements, both of which has been in socio-economically deprived areas where *'hardly anyone speaks English'*. As a result, she made the point that, she did not feel well-equipped to deal with women who were able to articulate themselves more fully, might be more informed and might question her care:

> *'... I feel sometimes a little bit deprived with this course and I don't know if we are getting equal training. I spent my first nine months at [hospital] and then the second nine months at [Case Site C hospital]. We had no choice, both are very low socio-economic areas and I'm terrified if I've got a woman that's very highly educated ... that's very demanding ... I have been dealing with Bengali women, 60% in [area] and hardly anyone speaks English in [Case Site C]. I have never been mentally challenged or like "Why did you do that?" and I feel in a way "Oh my god, if I go somewhere like Brighton and someone asks me something, I wouldn't know how to handle being with them."'* (Student 5, discussion group)

Previous research (Gerrish et al., 1996), as well as data from Case Sites A and B, point to the issue of staff and students lacking experience in caring for ethnic minority service users. This student drew attention to the fact that they may lack experience with affluent, well-educated clients appears to be a new one in the context of assessing the preparation of students to meet the needs of disadvantaged clients.

The data explored so far suggest that midwives, students and managers all saw equality of care as something that was not a reality but was being worked towards, with varying views on how this could be done and what obstructed it. These ranged from resources to individuals. When asked whether there was anything that the trust offered that helped midwives improve their understanding of such inequalities issues, a midwifery manager talked about teaching midwives to deal with complaints:

> *'There are in-house courses such as "Complaints Handling". Because some of the complaints which come through, they come through because people feel that they have been treated unfairly. They feel there are inequalities in the service. And it helps midwives to learn how to deal with situations. And, of course, improve the care that they provide as well.'*
> (Rhoda, midwifery manager)

However, Rhoda went on to suggest that those who might be most disadvantaged did not complain, as they did not know how to access the service.

It is worth noting that Case Site C was the only site in which complaints were raised by any participants, and it was only mentioned in relation to issues of culture and language. As participants thought aloud about the ways in which they dealt with cultural and language barriers, much discussion of the health advocacy service took place.

In all, five health advocates, representing different cultural groups and speaking different languages, were interviewed. Most spoke of their role in promoting equality through assisting women and their families to access care. Ursula talked about the language difficulties faced by many women and her role in supporting such women:

> *'I feel, with language being the biggest problem, people don't know what they are entitled to. That is when the inequality comes. Sometimes they are frightened to ask, especially, what I found recently was, with asylum seekers and women who had recently come to this country.'*
> (Ursula, bilingual health advocate)

Ursula went on to explain that part of her role was to complain when such things happened and to reassure women that they were entitled to a *'proper service'*. Ursula felt that one of the biggest problems faced by health advocates was that so many of their clients were simply unaware that they were entitled to any care. This was especially the case for asylum seekers and recently-arrived refugees.

Even where women were aware that there was a national health service, GPs often refused to register asylum-seekers and refugees and this, again, was something that Ursula thought was an inequality in provision. Several service users interviewed had experience of this, they spoke of being refused registration at several GPs' surgeries and said that they felt this was on the grounds of their ethnicity. It was not uncommon for service users to have to seek out a GP who accepted clients of particular ethnic groups. Many GPs themselves were of an ethnic minority group and the inter-racial politics in this case site were highly complex.

Isabella, another bilingual health advocate, similarly explained how her work with refugees and asylum-seekers was different to the work health professionals undertook with women who were settled in this country. She explained that ensuring that women's needs were articulated and met throughout their pregnancy often involved liaison with other professionals in health and social care work.

A bilingual health advocate said the following of some of her experience of working with midwives:

> *'... we are not always informed that a woman is on the ward and people have been in and out without seeing anybody and without understanding what they have been through ... The midwife, she is in a position of power and she chooses, she is the one who chooses to contact an advocate or not to contact an advocate. That is what we are trying to change. Our message is now that she should contact an advocate no matter what*

> *because she can't communicate with the woman. But many of them will say "Oh no, she understands" or they use sign language ...'*
> (Nawal, bilingual health advocate)

However, despite all the work they could do for their clients, the advocacy service was clearly limited and over-stretched. Both midwives and advocates found this frustrating, and this was cited by some midwife interviewees as a reason for not bothering with the service but rather choosing to 'get by'. A bilingual health advocate put her perspective on this. Talking in general about her clients, she said:

> *'If they come to hospital and I happen to be on duty they are lucky. But if they are ill after 5.00pm, I am not here. If they are ill before 9.00am I am not here. If they are ill at the weekend I am not here ... from April we will be launching a pilot project to assess the out of hours demand. After that we will know what we can do about it. Obviously everything is related to funding.'* (Isabella, bilingual health advocate)

This lack of resources to meet the advocacy demands of women in the community was of great concern to Briony, a midwifery manager:

> **Interviewer:** *'Tell me about your impressions/ideas about the health advocacy service.'*
>
> **Briony:** *'I think the health advocacy department do an excellent job, but they again are very under resourced. We are the only hospital in [area of city] who haven't got dedicated maternity advocates. That's partly due to the fact that we need so many different core languages. I think last time it was 37, and we use a huge number over and above that. It is difficult to have people that are dedicated when you require such a large number of languages. We do need to have 24-hour advocacy service, for all ante-natal visits and the delivery suite. Probably about 50% of our women would benefit from an advocacy service, and 25% of them desperately need them, as they can't speak English.'*
>
> **I:** *'What is the trust's approach to the advocacy service? Are they looking to develop it further?'*
>
> **B:** *'They are looking to develop it further ... it is being developed in dribs and drabs. We got some funding to develop it for advocates and HIV services, and we have got three dedicated advocates in our maternity services for ante-natal HIV testing, which has been great, really helpful. If you are HIV positive then you will always get a health advocate there.'*

This consistent emphasis on language needs is evidence of the stark contrast between the issues that concerned participants in this case site and those that concerned participants in Case Sites A and B. The contrast between Case Sites A and C is particularly striking. When asked about equality of care and related terms, respondents in Case Site A talked about individualised care and woman-centred care, with only brief reference to particular disadvantaged groups. In Case Site C, however, there is a sense in which such concepts become almost irrelevant as participants struggled to meet the basic care requirements of a culturally diverse and socio-economically deprived population. Notions of choice easily become relegated to second place as health professionals concentrate on simply communicating basic health and medical information to clients.

It is clear that the cultural diversity of the population was a major challenge for participants in this case site. Knowledge of different cultural norms and practices was defined as one of the key areas of knowledge needed by midwives and other health professionals in Case Site C.

### 8.3.2 Knowledge, skills and attitudes needed for midwives to promote equality of care

The following section analyses what knowledge, skills and attitudes service users, health advocates, midwives, students, educators and managers highlighted as being necessary for midwives to have in order to deliver equality of care. As before, the following areas will be discussed in turn:

- knowledge about the social/cultural context of women's lives
- understanding the nature and boundaries of the midwife's role
- attitudes and communication.

#### 8.3.2.1 Knowledge about the social/cultural context of women's lives

In different ways, most midwives were keen to demonstrate awareness of different cultural practices and talked about how they incorporated such knowledge and understanding into their practice. However, within this case site, there was also much discussion concerning the limitations of their knowledge in this area. A community midwife suggested that, during her training, she was not prepared for her current role:

> *'I would have appreciated as a student nurse and a student midwife much more input about the different cultural expectations of pregnancy … Issues about child-rearing, child protection issues. There are a lot of situations where something I would consider totally unacceptable is considered completely normal and that is where it becomes extremely difficult, even within different cultures of student nurses and student midwives. There was a child protection issue where the student midwife just didn't feel it was appropriate to be an issue. It was to do with repeated smacking of the child. So that automatically brought in conflict with her own upbringing about what is in her sense perceived as normal behaviour and what isn't. So that can be very difficult and that can set a lot of boundaries up between professionals.'* (Charlotte, community midwife)

Charlotte's account suggests that much more could be done within the education of midwives and other health professionals to explore cultural differences, not only amongst client groups but also amongst themselves. The ways in which such differences impact upon their care could be added to this exploration.

A midwifery manager discussed the need for understanding of different cultural practices around stillbirth. She did so within the context of making a case for further policy and guidelines for midwives concerning the needs of different cultural groups:

> *'It needs to be highlighted amongst the staff, particularly for midwives who have been in the same area for a number of years. They become rather complacent about the work they do. If we had a policy it would be good to ask people to revisit it every now and then and think about the work they do. Bereavement and stillbirths, we should have some documentation about what different cultures do to not cause any more distress. Some people want to take the baby home and bury it within 24 hours. And even if staff can't comply with that we should be able to sit down and talk it through with them and recognise their wishes.'*
> (June, midwifery manager)

A community midwife talked about Asian women in her care and their attitude towards parent education. She suggested that they might be more likely to come to classes if they saw them as appointments to be kept, rather than as optional extras:

170

> *'There needs to be much more education done in smaller groups and interestingly enough if I were to put an ante-natal education appointment on the card of maybe my Asian population, they would attend. If I were to ask them to come they would choose not to. It is about looking how we deliver ante-natal care.'* (Charlotte, community midwife)

A specialist midwife reflected upon different cultural attitudes and practices regarding HIV testing, following the introduction of HIV screening as part of ante-natal care:

> *'The women who tend not to test are women from cultures where we so far haven't seen very much HIV, for example the Bengali women. A common response is: "It is not relevant. We don't have this in our community."'* (Ali, specialist midwife)

Most midwives were well aware of the need to inform themselves about the different cultural needs of their clients. Some expressed a need for better understanding of the cultural contexts of women's lives or the needs of women facing specific disadvantages. Both midwives and students were able to identify recent practice situations where they felt they would have benefited from more knowledge in a particular area. For example, a hospital midwife expressed a need to know more about mental health issues in order to be able to deliver appropriate care:

> *'I find the mentally ill most challenging. Last week I had a schizophrenic couple. He was quite agitated, on medication. His girlfriend was very vague and she was small for dates. I couldn't get a proper story out of them, apart from the fact that I was in charge. So I couldn't sit down with them and get a proper story out of them. I felt at a loss really about what to do … And we don't get any training in mental health really. We only know a bit about post-natal depression. It's worrying. They do need a lot of care. And then there's all this stuff about child protection; are they able to look after a baby. And you think, what do we know?'*
> (Joanna, hospital midwife)

Students also expressed such a need. Jodie, a student near the beginning of the 18-month programme, was asked what she had been learning about inequalities issues that she had been able to make use of in practice. She responded:

> **Jodie:** *'The practical sessions, like when we do abdominal palpitations, those sessions I find very helpful. I can't see that with a lot of the sessions how I am ever going to use it in my day to day practice. I think something like, if we had a session, I don't know if one is coming up, on religion and culture and woman's health. I think things like that would be very helpful. I think we need to know more about dealing with clients in their cultural environment.'*
>
> **Interviewer:** *'That workshop (in the classroom setting) last week was … on culture?'*
>
> **J:** *'Yes, but where I was working before on the ward we had a booklet which sort of, you know, the "Dos and don'ts" of certain religions and cultures. And you were actually able to explore it further … a Jewish lady would come on to the ward and if I wasn't very sure of something, and I didn't want to offend that lady, I could refer back to [the booklet]. The workshop we had last week, I don't know if it was in-depth enough to actually look at the cultures that we as student midwives were going to encounter.'*

The thoughts that Jodie expressed above were common among respondents. Many students and midwives expressed a wish to know more facts and information about different

..171

cultures. One way of achieving this would be to promote one of a student's insights that you can learn a lot directly from your clients if done so in an appropriate and friendly manner:

> *'Sometimes [clients] give you the opportunity to learn about them, like "I'm wearing this because ..." Also in the home you get a lot of opportunity to learn.'* (Sabrina, student)

Whilst midwifery education may be said to implicitly acknowledge this, demonstrated by a strong focus on community placements, it is possible that students could be more explicitly encouraged to see clients as their educators. In this case then, classroom education that focuses on self-awareness and examining one's own prejudices would complement such a practice and enable students to learn from service users in a positive manner.

The challenge for midwifery education to get an appropriate balance between helping students to formulate understandings of cultural groups whilst encouraging an individualistic approach to care is apparent. Many students and midwives felt that whilst they acknowledged everyone as an individual, they would also like education about more specific cultural beliefs and practices. From our research at the university, it was clear that an attempt was made to deal with these issues through a study day by an outside expert which addressed the themes relating to culture and childbearing.

Notwithstanding the importance of developing individualised care which is sensitive to intracultural difference, it does seem a useful starting point for midwives to have basic knowledge of cultural norms from which an appreciation of difference can emerge. Certainly the data suggest that this would benefit the women being cared for. For example, Vetheda, a Tamil woman, felt that her care could have been improved with greater understanding of Tamil culture:

> **Interviewer:** *'Do you have any suggestions for how your care might have been different?'*
>
> **Vetheda:** *'The food. I was not happy about the meals. I was breastfeeding. In Tamil culture you don't eat normal food after delivery, you have special cooking with lots of herbs and no meat. You won't digest well and have gas problems. The special food helps to involute your uterus.'*

Thus in Case Site C, unlike in Case Sites A and B, discussions of the importance of understanding about women's backgrounds mainly focused on midwives' knowledge of non-western cultural practices and beliefs. In the other case sites, discussions around understanding difference were concerned with such issues as poverty, substance misuse and teenage pregnancy, primarily within a western context.

### 8.3.2.2 Understanding the nature and boundaries of the midwife's role

Given the massive inequalities in health faced by so many of their clients, it is perhaps not surprising that one area of great concern to many participants in this site was to establish boundaries to the midwives' role in terms of responsibilities for addressing such inequalities. As the discussion below suggests, most acknowledged that midwives had a key role. However, they emphasised that there had to be clear limits to this role, and an ability to work with other health and social care professionals as part of a multiprofessional team, when dealing with service users with such complex constellations of disadvantage.

Views about the midwife's role did vary amongst midwives. A community midwife felt very clear that her role had changed from traditional midwifery towards a more general health advocate role, a change she described as 'de-skilling':

> *'I think, in this area, for me, I feel fairly de-skilled as a midwife ... because we have had to move away, or I have moved away, from our role as a midwife and being more of the health advocate, I think, for the*

> *family. The very in-depth discussions that you would have relating to ante-natal screening, or their perception of their pregnancy, is just doesn't happen. Instead it's "Why is your six-year-old not at school?", "Are they up to date with their vaccinations?", "Are you fasting at the moment? What do you have for breakfast?" You know, the sorts of things when I qualified as a midwife I wouldn't consider relevant at that point.'*
> (Charlotte, community midwife)

It is interesting to note that Charlotte's notion of de-skilling is based on a more traditional view of midwifery as a distinct sphere of practice relating to pregnancy, childbirth and post-natal care. Charlotte said that her pre-registration midwifery education did not prepare her for the broader, public health approach that she was now undertaking. This approach is espoused in contemporary policy documents such as *Making a Difference* (DoH, 1999a). Charlotte demonstrated extensive knowledge of current health policy and as such was aware of midwives' broadening agenda. It is then of great interest that she sees this as de-skilling. Indeed, one might even suggest that other midwives across the case sites shared Charlotte's concerns, although none articulated them in precisely the same way. In analyses of the midwife's role in relation to inequalities across the case sites, midwives expressed concern and confusion regarding where their professional limits lay. Thus it appears that the very notion of what constitutes the identity of a modern midwife is increasingly contested.

A community midwife was clear that it was her responsibility as a health professional to find out about the specific needs of a woman with mental health problems that she cared for:

> *'Any problems I might have is that I don't know who to approach and if I don't know directly who to approach then I will find out. If I feel that, let's say for, like at present, I am trying to find out some information about this lady with mental health problems. I will get as much information as I feel I need to know and then I will then go to her and say "Have you got A, B and C?" If she hasn't then maybe suggest these are the things she could apply for and things like that.'* (Iawa, community midwife)

This approach of finding out in response to individual client needs could go some way to relieving the anxieties of students and midwives who feel they have to know everything.

Macy, a community midwife, clearly felt that it was a midwife's responsibility to care for all women equally no matter what their circumstances and however difficult it may be for the midwife personally. She talked about one client who she felt was particularly disadvantaged:

> Macy: *'... She used to be a traveller, she now has permanent residence but she has shown self neglect to herself and her family. Her living situation leaves a lot to be desired and she has ended up with a lot of infestations, to put it politely. Because of that she is more or less shunned by the medical profession and people are reluctant to go there. I suppose it is understandable, and I feel somebody like her doesn't receive the best care.'*
>
> **Interviewer:** *'So when someone like that, who doesn't actually come forward and say, do you think it is the responsibility of midwives to then pick up on that and then offer?'*
>
> M: *'Yes, because half the time they don't really know what their entitlements are. So you have to help and empower them, educate them and tell them what they can and can't get.'*
>
> I: *'How do you become familiar with what their entitlements might be?'*
>
> M: *'Mostly by liaising and asking, finding out. Because you can't get everything from a book. Things change so much. So it is very useful to work closely with other agencies.'*

> **I:** *'What are the limits of the midwife's role, say, in a case like that, how far can you go to give them support or help?'*
>
> **M:** *'We are limited in the sense that we can't sanction things, you have to recommend and pass it on. Once you have done that you don't know how long it is going to take, you don't know how far they are going to go with it, you can only re-check and re-inform and chase them up. At the end of the day too, she is not having an obstetric problem, she is fit, baby is fit, they are both discharged so your responsibility ends there really. You have to then pass it on to the agencies that deal with that part of the situation. Yes that is where your limitation comes in because that is not your remit.'*

Macy's account suggests that she was clear that she had a responsibility to care for all women as best she could. However, she also considered her role to involve close liaison with other professionals and facilitate the birth of a healthy baby to a healthy mother.

Ali, a specialist midwife, reflected on midwives' responsibility for addressing inequalities. She felt that her own role, as a specialist midwife with a particular field of expertise, required her to take more responsibility than other midwives around inequalities. In the following extract Ali talks about the midwife's role and her own:

> *'I think midwives are burnt out. I often think that once the midwife fills in a referral to a social worker, she feels that is all she can do. Because once it is done then it becomes somebody else's problem if you like. I am in a situation where I get to know women quite well and get to know a lot more of the detail of their lives which perhaps a midwife working in the clinic or on the ward might not … I think it's all very understandable.'*
>
> (Ali, specialist midwife)

Ali was sympathetic towards midwives who felt overstretched and unable to deal with the many problems faced by the women in their care. Having practised in mainstream services herself, she also had experienced this. For her, there had to be limits to the midwife's role. She was in favour of the development of the specialist midwife who could provide a focal point for particular problems and take on a co-ordinating role, giving non-specialist midwives support and advice as needed:

> *'I think in areas where there needs to be a lot of co-ordination and where there are clear benefits to some kind of consistency [it would be good to have specialist midwives]. Obviously, all midwives are trained and should be giving the same information on a consistent basis. But I think when you have got something like HIV, that is very distressing, or diabetes, which can be very confusing, I think it is good practice for somebody to build up a relationship with one other person who can take them through. So yes, I do think there is room for a lot more specialising and I think it is a balance between having a specialist focus and not de-skilling the generic midwives.'* (Ali, specialist midwife)

Students also talked about the midwife's role and its limitations in relation to inequalities issues. For example, Jenny, a student on the 18-month programme was clearly of the opinion that given the practical realities of providing midwifery care in Case Site C, the midwife's role in relation to complex issues of disadvantage was limited:

> **Interviewer:** *'If you think about the domestic violence session … If you as a midwife or student midwife had a woman in that situation where would you draw your limits, how far do you go?'*
>
> **Jenny:** *'I think it would be nice to discuss things and then refer her on to whoever, locally. If you give the information, and it would be nice if you*

> *have a plan of action and you kept on top of it and knew what was going on. But I don't think it's practical really. I mean you're so busy that you don't have time to keep doing these follow ups months and months later. You refer them on and that is where your responsibility stops.'*

Jenny's suggestion that the midwife's role was to 'refer them on' raises interesting issues about the precise model of teamwork being operationalised here. This is a clear example of an elective philosophy of team work, which, as Freeman et al. suggest in their study of clinical teams:

> *'... was essentially a system of liaison. In our studies, it related to those professionals who preferred to operate autonomously and referred to other professionals as and when they perceived there was a need. It was synonymous with insularity of practice and thus inhibited the development of a shared understanding of patient care.'* (Freeman et al., 2000: 241)

However, in Case Site C, the reasons behind midwives working in accordance with Freeman et al.'s philosophy may have had more to do with resource constraints than professional preference. These comments can be seen to apply to some extent to the lack of an integrative approach to teamwork between midwives and health advocates, a subject already discussed in Section 8.3.1.

One fieldworker observed some teaching sessions on domestic violence. It was clear that, in this case site, teaching on domestic violence was constructively related to midwifery practice. Furthermore, the lecturer was clear and realistic concerning the limits of the midwife's role, giving students clear advice regarding when to refer on to other agencies etc. Despite this, the above student was clearly of the opinion that in the reality of practice, referrals would not be followed up. This furthers the view, in Case Site C, that the concepts of integrative multiprofessional teamwork and holistic care were manifestations of a vision constructed in the educational context, rather than an actual practice reality.

Whilst there was no clear consensus amongst students and midwives regarding the precise role of the midwife, all were able to reflect on their experiences and question what those limits should be in specific cases. The following are some views of students who were about to qualify, taken from the focus group:

> **Interviewer:** *'How far do you think a midwife's role/responsibility goes if you have someone with several issues, like maybe they are homeless, using drugs, have no support. How far do you go and how far have you seen midwives go in trying to deal with this kind of situation?'*
>
> **Student 3:** *'Some have knowledge and are used to working with these people and make an effort to liaise with the experts, but not just fob [clients] off, but really get involved in their care and try and understand more about drug problems.'*
>
> **Student 7:** *'As a co-ordinator of care you have to deal with it and as the woman's advocate. But not one of us can be interested in all areas and be an expert in all areas and that's knowing your own limitation and your own interest at the end of the day. As long as we refer and make sure that the woman is receiving care we don't necessarily have to get involved personally at a deeper level.'*
>
> **Student 1:** *'It's knowing your own boundaries as well. The important thing for you is that you liaise and know your limitation as a midwife. You do have a certain time when you have to back off a little bit because they have sometimes so many problems ... I mean I wrote to the housing about one woman and I was told later it was an absolute waste of time and not my remit.'*

**Interviewer:** *'Who told you that?'*

**Student 1:** *'The senior midwife.'*

**Student 3:** *'I had a woman the other day and she talked to me for quite a while and she was disillusioned with some advice a doctor had given her. She had decided to go against his advice ... We were just sort of being nice to her because she was already disillusioned with one group of health professionals, the last thing was for us to start telling her to do things. She's pregnant so our role is to look after the woman and the baby. You've got to remember what your role is.'*

The above is an interesting and rare example of a midwife accepting her client's decision to go against medical advice. It seems that the midwife was actually in accordance with Page's vision to act as a professional friend rather than to ally herself with other health professionals (Page, 2000). Some components of Page's vision are shared by Pairman (2000) in her exploration of the relationship between midwives and service users in New Zealand.

Thus, there seemed to be some consensus amongst midwives and students that there are limits to the midwife's role and that referral to other specialists and health professionals was appropriate. The problem seems to be who will co-ordinate care, who becomes the lead professional and where does the midwife then place herself in relation to other professional involvement? It is also worth remembering that, whilst referral in theory sounds straightforward, some midwives spoke of having limited access to telephones and social services/workers being difficult to access. Improved resources and better communication between professionals could reduce time spent on such things.

In Case Site C, a central aspect of multiprofessional teamwork for midwives was their work with health advocates. Bilingual advocates were asked about midwives' responsibilities for addressing inequalities in health issues. Isabella's advice for midwives who were trying to improve the way that they delivered the service was:

> *'They have to be trained to work with health advocates. Most of them don't know how to work with health advocates.'* (Isabella, bilingual health advocate)

In the data for this case site, there were different understandings amongst midwives regarding the role of the bilingual health advocate. Some health advocates felt they were only called on in an emergency and even then only used to translate, rather than being seen as an essential part of a multidisciplinary team. Interviews with both midwives and the advocates themselves demonstrated tensions in their relationships. Midwives often felt frustrated by the unavailability of the advocates, and some also mentioned doubts about whether the advocates were translating exactly what the midwife said to the service user. This expectation of the advocates' role was often challenged by the advocates, who saw their role as much broader than 'translation work'.

Whilst there was much agreement across the board that the health advocacy service was under-resourced and should be expanded to provide 24-hour care, no midwife said that it was beyond her role to be expected to deliver care to clients with whom she could not fully communicate. Many talked about 'getting by' with the odd word and sign language. Many expressed frustration and anxiety about not being able to fully inform clients, but accepted it as a consequence of working in Case Site C.

Several health advocates interviewed said it was part of the midwife's role to get to know and understand a bit about her clients' culture. This is what midwives themselves consistently said they wanted and needed. Health advocates saw it within their own role to provide information and education to midwives and other professionals about the cultural groups they worked with. Some educational sessions were provided by the health advocacy service to health professionals, specifically about the role of the health advocate. However, there were plans to take forward the educational role of health advocates in informing other health professionals about cultural issues. Here, funding was a major inhibitor. With such a limited service in operation it would be difficult for advocates to be released on a regular basis in order to train health professionals.

A point made by a bilingual health advocate in relation to multiprofessional teamwork was that midwives should work with health advocates to set up culturally-specific ante-natal classes:

> *'Midwives set up ante-natal classes without health advocates. They set them up in the evening and we don't work then. My community doesn't want their views challenged in front of lots of other people. There's a cultural barrier for the men coming with the wife to another community group. If they found the same cultural group they would probably come.'*
> (Susila, bilingual health advocate)

This point is backed up by Priestley's observations that ante-natal classes set up for Asian women were successful because they advertised that a link worker would be in attendance (Priestley, 1997).

Clearly, there are issues of interprofessional boundaries when health advocates, midwives and service users work in partnership, further complicated in the bilingual setting where the advocate is often of the same ethnic/cultural group as the clients and may even know each other outside work. Both midwives and advocates referred to service users as *'their clients/their ladies'*. It may be that in this case site, issues of professional ownership need to be further explored in order to ease the way for improved multiprofessional teamworking. Some of the difficult issues identified in these interprofessional relationships and multiprofessional teamwork can only be resolved by the development of ongoing, close communication and understanding between the groups concerned. During the feedback session, this was explored further in discussion amongst midwives, health advocates and managers.

It seems clear that the importance of good, interprofessional working relationships were recognised as crucial to the delivery of equality of care. However, the inevitable tensions were exacerbated by the combination of large caseloads, poor institutional resources and service users with constellations of disadvantage.

### 8.3.2.3 Attitudes and communication

In this case site, communication was exacerbated by the vast diversity in languages spoken, and different cultural norms and expectations. Two managers interviewed raised the issue of complaints as a feedback mechanism. As discussed in Section 8.3.1, Rhoda saw complaints as a feedback tool for midwives to learn about the care they gave. June discussed how she regularly had to deal with complaints based around cultural misunderstandings:

> *'The most common complaint is more cultural than anything. Patients will ask for something and they don't always say "Please". Staff think they're demanding rather than asking.'* (June, midwifery manager)

Briony, another midwifery manager, explained that an innovative mechanism for using complaints as a learning tool was in place at this site. This was done by getting together the midwives involved in the care given to the service user making the complaint and having a reflective session using the complaint as a focus. The purpose of this was to create a non-threatening environment where views and opinions could be explored, and learning take place.

One non-English speaking service user reflected on the importance of midwives' facial expressions in the communication of positive feelings. She had already said that some midwives were simply 'nicer' than others, and was asked what qualities made one midwife nicer than another:

> *'The difference I think is when you talk … by the face, by the expression you can tell if the person is friendly or not. There are some when you talk to them they speak to you smiling. They talk to you with friendliness; they smile at you. There are others that are not very friendly. But everywhere is like that.'* (Madelaina, service user)

The importance of midwives being friendly and kind has arisen in many previous studies (e.g. Oakley, 1992). Several service users interviewed talked about the importance of having an 'open face'. Asha, a Somalian woman, felt herself to be disadvantaged by her inability to speak directly to health professionals and by the attitude and poor communication skills of some of the midwives. She developed medical problems following her delivery and had a fairly long stay in hospital. Some of this time she was deemed to be highly infectious due to a virus. During the interview she expressed strong feelings about midwives who had cared for her, some positive and some negative. She was asked to comment specifically on what made one particular midwife 'good':

> *'She was compassionate, she had an open face. She used to know I was in pain, she'd say "You go and relax, I'll bring you something." She used to ask me, when she was not there, how other midwives were. One midwife said about me "She's been here 15 days and she wants to be treated like royalty." The senior midwife wrote instructions and notes for the night midwives but nobody used to bother with them.'* (Asha, service user)

It appears that this particular midwife was acting as an advocate for Asha. Part of the advocacy role appeared to be protecting Asha from attitudes of her midwifery colleagues. Asha also had input from a bilingual health advocate, contact with whom increased as she experienced the hospital care she was receiving to be deteriorating. The advocate involved had the following to say about Asha's care:

> **Bilingual health advocate:** *'It was worse than someone with HIV. I have never seen a person being treated in this way.'*
>
> **Asha:** *'They used to talk about me. I know some words and I would hear them. They wanted to distance themselves, they used to feel disgusted. I said to the doctor "What do I have in my skin? Rats, cockroaches, maggots?"'*

Asha went on to reflect how midwives could improve their care. She suggested that they have a responsibility to reflect critically on the care that other midwives give. Across the three case sites, students and midwives could recall times when they felt colleagues displayed inappropriate language or actions towards clients, including stereotyping and prejudicial treatment, but most felt unable to challenge this. In this context, feedback mechanisms need to be explored; how do midwives learn about their own practice? At this site, complaints have been identified as a useful learning tool. Throughout this study, the reflective process has been discussed as a means by which midwives can learn about themselves. Furthermore, as suggested by Asha, there may be more scope for peer review of practice, to learn about one another's practice and reach a consensus concerning appropriate care. A recent evaluation of a model of peer review developed in Scotland defined peer review as *'an encounter between persons equal to each other in professional education, qualifications and position, in which one person's professional pursuits are examined, discussed and critiqued by the other's'* (RCM, 2000c: 2). The study described midwives as *'overwhelmingly positive about the experience'* (RCM, 2000c: 2). Thus, there may be scope for similar projects to be implemented more widely.

Supervision of midwives is also relevant to evaluating and reflecting on care. In all case sites, many midwives laughed when supervision was mentioned; very few had ever received supervision. Swann (1997), in linking reflective practice with the supervisory process, states that without the guidance of a sympathetic, empathetic supervisor of midwives, reflection would not be useful. She describes a process that requires honesty between both parties, but reports that she did not experience this, other than with an education-orientated supervisor. Given the lack of supervision that appears to be in place and the power dynamics affecting the relationship between supervisor and supervisee, peer review may be a more realistic option for promoting reflection in the midwifery context.

Nura, another service user, commented about midwives' communications skills and attitudes towards people from cultures different to their own. She had had three babies at this hospital and in her opinion, had seen midwives attitudes becoming worse:

> **Nura:** *'The midwives attitudes are getting worse now, over the three experiences, I'm not going back now. They have no civil way of approaching the person, they are more rough with the patients.'*
>
> **Interviewer:** *'Can you give me an example of that?'*
>
> N: *'During the labour, the baby's head is coming out, you need to walk around so the labour will come quicker, they (midwives) tell you, the whole 12-14 hours, to lie down. They want to monitor the baby.'*
>
> I: *'Did you ask to walk around?'*
>
> N: *'Yes. They said "No." They wanted me to sit so they could monitor. The baby will come out. In Somalia there is no doctor, if you have faith nothing will go wrong. They behaved as if the baby was going to die any second. They have to improve their attitudes.'*
>
> I: *'Did you explain your beliefs to the midwives and doctors?'*
>
> N: *'Yes, but they didn't listen.'*

Of course, in this situation there may have been good clinical reasons for the actions of the health professionals. Our purpose here is not to represent the clinical facts, but to document the client's perspective on events. As with many other women, Nura talked about the need for midwives to be *'open-faced'* and to look positive, especially where they were unable to communicate with clients in words.

A bilingual health advocate also talked about how her clients complained of poor communication skills amongst midwives. She felt angry that the health advocates were often only called when communication had almost completely broken down:

> *'They contact me when they're in a sticky position. When things come severely bad, bad, then "Oh, we need [language] health advocate to sort it out" and they leave the mess to me, to clean it up. But they don't call me when the lady is in need. The only time they call me is when her husband is in an attacking situation. So I have to calm the whole place down. The husband is shouting, and the doctor and the midwife wanting certain things, it's very, very sticky place.'* (Maryan, bilingual health advocate)

Maryan also talked about the difficulties she faced when the women for whom she was advocating and the health professionals wanted different things. In the example below, she was caught between respect for the woman's cultural practices and beliefs, and the doctors' medical opinion, which conflicted with such beliefs. The woman was refusing a caesarean section, preferring to put her faith in Allah. Maryan spoke of her difficulty in trying to communicate both with the doctors and with the woman:

> *'She was saying "I don't care. No, I'm not going to have caesarean". The doctors say "We don't have time, the baby's heart is in distress" She said "No, Allah will give me baby, he will take my baby". But the doctors put pressure, pressure, pressure. I was trying to put this pressure on to the patient and the patient was saying "No, I don't care, I'm going to try". And the husband wasn't helpful too, he was saying "No, she is not going*

> *to have caesarean. Always you're making excuses to have our ladies sectioned. Always saying there is something wrong with the baby. And it's not true. Most of the time our babies are healthy."'*
> (Maryan, bilingual health advocate)

According to Maryan, this situation continued for over 24 hours with doctors continually pressurising the woman. Again, while there may have been good clinical reasons for this, our purpose is not to represent clinical facts, but to document the health advocate's perspective. In the end, in Maryan's absence, the woman consented to the caesarean and the baby was born healthy. Maryan went on to explore her own confusion about how to recognise what is right in such situations, as well as the stress she herself was put under in this case:

> Maryan: *'But you don't know what to believe. The [CTG monitor] is saying this, the doctors are saying this, and the woman is saying this. So you don't know what to believe. So I was in a situation saying "Listen to the doctor" and we were brought up in a culture where you have to listen to the doctor. So I say "Listen to the doctor, this is what the doctor is saying", "I don't care about the doctor." I was feeling scared. I couldn't sleep the whole night thinking, "What's happening to the baby?", thinking, "Did you do your part? You didn't persuade the wife enough. Did you persuade the husband enough? What's going to happen if the baby die? What am I going to see tomorrow?" My heart was pumping hard.'*
>
> Interviewer: *'How did you feel about what the woman was saying? She was saying Allah will take care?'*
>
> M: *I felt the woman was very, very brave ... she must have a lot of faith for her to say "No." To say, "No" for two and a half days. Oh my god. There was a lot of pressure ... The doctors were saying, "You are responsible for your baby's death, you understand?" So I have to turn to the woman and say, "You are responsible for your baby's death." So it didn't look nice, although you distance yourself but it doesn't sound nice to tell the lady this, it felt bad.'*
>
> Asked what she thought of the midwives involved, Maryan replied:
>
> *'Midwives, they didn't say a lot because they were running around. They were going to the doctor instead of approaching the patient directly. They were reporting to the doctor. So the midwives, they became robots to the doctors.'* (Maryan, bilingual health advocate)

This notion of midwives following doctors' orders rather than acting as advocates for women has been raised in many studies (Kirkham, 2000). Accounts such as Maryan's illustrate that, in some areas, midwifery is far from realising the vision put forth by midwifery commentators who see midwives as the professional friends of their clients:

> *'In the new midwifery the best midwives are like professional friends to the women, caring for her through pregnancy, birth and the early weeks of her child's life in a way that increases her personal strength and autonomy in preparation for the responsibilities of motherhood while providing appropriate support.'* (Page, 2000: 8)

In a later discussion, Maryan related how, following the event, the woman concerned had accused her of putting too much faith in the doctors and not enough faith in Allah. Maryan had found this deeply distressing. She found herself caught between her religious beliefs, which concurred with those of her client, and the dictates of the medical model. This led her to question the strength of her faith. As Teasdale (1998) suggests, the kinds of stressful events and issues which Maryan faced are common amongst health advocates.

The challenges of working in such a diverse population were evidently felt by staff and service users alike in this site. It was not only clients who felt offended by staff attitudes/communication but also *vice versa*. During the fieldwork, inter-racial tensions were felt, and on several occasions service users openly expressed racist views and a preference for a midwife of a particular race. When this was discussed in the feedback session, the midwives present, of varying ethnicity, agreed with this finding. They were not surprised that service users had expressed racist views and felt that they experienced this often. Working in such an environment must undoubtedly put extra strain on achieving good and effective communication.

### 8.3.3 Midwifery education re: inequalities and the delivery of equality of care

As in Case Sites A and B, the research sought to investigate educational provision in relation to inequalities. The following issues arose in interviews and are addressed in turn:

- teaching and learning about inequalities
- theory-practice links
- the importance of practice placements
- the importance of reflection
- the assessment of understanding of inequalities issues.

#### 8.3.3.1 Teaching and learning about inequalities

From analysis of curriculum documentation it was clear that there was strong emphasis on issues of inequality which permeated the curriculum. In this case site, as in the other two, both students and lecturers believed that such issues were covered.

A senior educator was asked about the strengths of the new three-year direct-entry programme in terms of addressing inequalities issues. She felt that students learnt a great deal from the *'clientele that is served by the trust'* and gained valuable experience about inequalities. She went on to describe how the problem-based learning approach used in some modules was also useful in enabling students to deal with inequalities issues:

> *'What we try to do, we are using problem-based learning and certainly one of the triggers … was specifically about investigating the resources available or required by women in disadvantaged positions. So we gave them scenarios, which involved women who were refugees, women who were homeless, who were experiencing domestic violence, racism and so on … They actually had to go out and find the community-based facilities that would address the issues that the women were facing … It was one of the most successful, they really went at it hammer and tongs, partly because a lot of them identified with some of the situations. We had one woman who was struggling at that time to get her student status established and so issues around nationality and status were really important to her. It was a very successful little enterprise.'* (Sarah, senior educator)

As in Case Sites A and B, lecturers tended to represent inequalities issues as being addressed implicitly rather than explicitly. Sarah's view was typical:

> *'When I am reflecting on it I think we did manage to address it, not under the title of inequalities, but more as a kind of integrated dimension of how you look at the needs of women and how you assess their needs.'*
> (Sarah, senior educator)

Assessing and meeting women's needs were, then, considered central to the delivery of equality of care and central, therefore, to the teaching programme in terms of issues of inequalities and disadvantage. It is therefore surprising, perhaps, that when asked to talk more about how the concept of women's needs was approached, Sarah was rather unclear and non-specific. Asked whether she thought students had a clear idea about what the concept 'needs' implied, she was equivocal, saying that those who had been nurses might be better off in that respect than non-nurses but in the end, she concluded:

> *'The fact is I don't know. (a) I don't know whether any of my colleagues addresses it in a formal way and (b) it may well be true that it should be because it may be something that we are taking for granted that is understood by students, and it may well not be. Except in that kind of indirect way. We are trying to talk about cultural needs and that sort of thing but maybe it does need to formalised.'* (Sarah, senior educator)

Sarah's difficulties with defining need, and its operationalisation, is shared by other midwives (Hart, 1997). Chapter 3 explored the many different interpretations that may be assigned to the goal of fulfilling women's needs. Given the confusion surrounding this central, yet seemingly contested concept, it may be worthwhile lecturers explicitly addressing the concept at the beginning of the programme.

An educator was very explicit about the inequalities focus of her teaching. In particular, she was keen to unpack concepts that could be used rather uncritically in midwifery, such as empowerment:

> *'Is empowerment just a word we use and is bandied about? If you haven't had the education and you haven't learnt that you can make requests, then how can we help women to understand what they can be empowered with? We tell the students you can use the word empowerment as a concept, but in reality how can you help women to be empowered in discussing with them in the ante-natal setting if they're asking for something you can't give realistically? An example of this is that I do an ante-natal clinic. I say to the women, "Let's do your birth plan." They say "We'll do anything that you want, anything that you say is OK." And I'll say, "We need to look at what is the best available for you and I'll go through it." I might say, "Who have you decided will come with you?" She'll say "I haven't made up my mind." I'll say "You have to make some decisions about who will come with you, they may say only two people are allowed with you on the labour ward." In the past people have come to the labour ward with 13 or 14 people and that's impractical.'*
> (Thandi, educator)

Thandi made the important observation that when talking about choice, control and decision-making in pregnancy, student midwives should be encouraged to recognise that for some women, these may be alien concepts:

> *'... particularly Bengali women. We say they should be making choices and decisions and from their cultural point of view they don't make decisions. There are different roles within their society that we have to work with and getting the students to understand that it might not be the woman who makes the decisions because it might be the husband's role to make decisions can be difficult for students. We get them to think about another situation, if they were abroad and with their value system in another country, how would they feel?'* (Thandi, educator)

Gayle, another educator, thought that teaching about inequalities issues began at the selection and recruitment of students:

> Interviewer: *'How would you say then that students are taught about issues relating to inequalities generally and inequalities locally, where they are working?'*

> **Gayle:** *'Well it starts at selection and recruitment. I'm responsible for selection and recruitment … We get people applying from all over the country. If you're used to living by the sea with lovely hills behind you and nice wood and bluebells, just a short stroll, and you've got fresh air, nice places to eat, nice places to go, and that's important to you and it is important for a lot of people. I ask them to think seriously about what it would be like working in this environment all the time and for some having to live in it. Living and working in this environment … So I ask people to think about those sorts of things … Because poverty seven days of the week can pull you down, it can be very depressing. This is a depressed area.'*

Later Gayle suggested, as had some of her colleagues, that students learn about inequalities from each other:

> *'The school is very multicultural so they can learn some aspects of it from each other. From the students themselves, and also in class. There's only one English person in the set that have just qualified; what you would call a white English. There is Scottish, Welsh and Irish. There is Trinidadian, there is Indian, Ghanaian, Mauritian, Antipodean.'* (Gayle, educator)

She commented that she liked to think that students qualifying from this institution were ready to give equality of care because of their experience of working in such a multicultural environment:

> *'I like to think that the midwives that come out of the school here would not disadvantage a social group because they didn't understand them, and that they would give good equality of care to all women. I think because they work in such a multicultural environment that they are afforded the opportunity to understand different women. We talk about woman-centred care and I hope that as a result of what they've been exposed to that they give woman-centred care and not rote-learned care.'* (Gayle, educator)

Whilst Gayle's vision is laudable, it was clear from discussions with students and midwives that such a vision was not currently realisable in Case Site C. Resource issues and structural inequalities were perceived by many respondents to be a major determinant of how care was delivered.

A senior educator talked about the use of both the advocacy service and other user groups in the classroom and the ways in which such representatives could expand students' awareness of inequalities issues:

> *'We have the advocates. Two of them came in and did a session with the students and that was well received. And the other thing that we did, which was an eye-opener for me as well, was that we invited people from [local parents programme] to come and speak to the students. They brought a whole panel, it was wonderful actually, there were about five women, all of whom at some time had been recipients, no four of the five had been recipients of [the programme's] support. Three are still users if you like and one of those four is now a co-ordinator … These are women who are suffering depression, mental illness, various kinds of marginalising and disabling conditions. It was, you could see they were really nervous about coming to a group, but it was a very powerful experience for the students.'* (Sarah, senior educator)

A group of students just about to complete their 18-month programme discussed how inequalities issues were taught on their programme. There was a strong feeling that whilst they had learnt about issues, this may have been at the expense of learning 'the rudiments', such as physiology:

> **Student 1:** *'We've had very much woman-centred care throughout all of our course and that's been a very strong theme.'*
>
> **Student 5:** *'… they've really gone into woman-centred care, choice, Changing Childbirth, blah, blah, and all that but I don't know if they've really drummed in things like physiology. It's a bit worrying.'*
>
> **Student 3:** *'I know the social science aspect is important. We've done a lot and we've all brought a lot from all around the world in this class, and that's been very valuable with regards to inequalities and lots of different opinions, but the actual rudiments [of clinical midwifery] sometimes have been missed I think. I feel really strongly about that.'*
>
> **Student 2:** *'It's only through clinical practice really we get that [the rudiments].'*
>
> **Student 3:** *'Totally true.'*

Later, Student 7 praised lecturers for their knowledge of inequalities issues but, again, suggested that such knowledge might be at the expense of clinical knowledge:

> *'But in all fairness if we go back to equality of care, if you approach the lecturers about equality of care, there is a strong feminist feeling and belief here among the lecturers and they're all very, very good about this topic. They may be rubbish when it comes to physiology but when it comes to equality I would say they're very good.'* (Student 7, group discussion)

Whilst Student 5 commented that the feminist perspective was *'no bad thing'* because *'that's what's missing from the clinical area'*, Student 2 thought too much emphasis on such issues at the expense of *'the basics'* could lead to dangerous practice.

The issue of the appropriate balance to be achieved between different parts of the curriculum arose in another similar study, in relation to the needs of ethnic minority clients (Gerrish et al., 1996). It was raised by Jenny, an 18-month student near the beginning of her programme, in relation to teaching on domestic violence. Although she felt it was important to understand about domestic violence, she felt that spending three months focusing on just this one issue was excessive.

Problem-based learning is a relatively new concept in midwifery. Thomas et al. explain that *'an evidence-informed approach to learning provides a model of education which can be usefully compared to the midwifery philosophy inspired by Changing Childbirth'* (Thomas et al., 1998: 264). They go on to claim that it will help to prepare midwives who are truly woman-centred. This approach has not yet been fully evaluated but while the early signs are favourable, their comments are based only on mentor and student feedback. Problem-based learning is reported to lead to deep learning but it is important to consider the nature of the content of that learning.

As stated above, students' concerns about curriculum content were often related to their worries that 'the basics' were not adequately covered. In the following discussion, this was also linked to the approach to learning on this programme. The students had been discussing the pros and cons of 'spoon-feeding' and the self-directed approach to studying, as practised on their programme:

> **Student 3:** *'… I think we've just all been subjected to a different type of learning and we're not used to it. We're used to someone saying "This is a uterus" and so on and telling us things. This course is telling us through research and it's bloody difficult but that's the deal, that's what being an autonomous midwife is. You're not nursing anymore, so it's complementing you in your role as it were.'*

**Student 6:** *'I think through this course we've been taught to question things via research so hopefully, maybe, we haven't had some of that teaching "at you". But hopefully you are learning and you are questioning things so you're not becoming one of those people who just do things because they've always done that.'*

**Student 7:** *'I personally hate the practice of teaching "at you" because I think it doesn't value you as an individual. If you're going to talk about equality of care, woman-centred, and respecting individuality to clients but you're not respected yourself I think that's hypocrisy.'*

**Student 1:** *'I agree with that to an extent but I think the absolute basics are not covered enough, that you need to know. With these direct-entry midwives this is a basic thing, they're out there, they're in the clinical area with us now and they can't do blood pressures. That is a basic thing that they should be learning before they get on the wards, because when they're on the wards they do the job.'*

**Student 3:** *'Oh no. When I was a student nurse I couldn't do a blood pressure. It just comes.'*

In terms of how teaching and learning about inequalities took place, then, there appeared to be a strong feeling amongst students that the balance between clinical and socio-cultural aspects of midwifery in their education may have been too much in favour of the latter. They felt that this might prove problematic in their practice.

Students obviously felt that lecturers were very knowledgeable about inequalities. This is interesting in the light of the study by Gerrish et al. (1996), in which lecturers emphasised the inadequacies in their own ability to teach students about providing care to minority ethnic clients. Such issues were not apparent amongst lecturers at Case Site C.

Overall, there was a sense in which both lecturers and students felt that much learning about inequalities issues came directly from the experience of working within a culturally-diverse and socio-economically-deprived population. This comes up again in the following two sections on theory-practice links and the significance of practice placements.

### 8.3.3.2 Theory-practice links

As in Case Sites A and B, there was a strong sense that practice was the most important educational domain for students. Both midwives and students were critical of the gap between what happened at the university and what happened in practice. As in Case Site B, despite the fact that midwives revealed only a vague understanding of what occurred in the university, the fault for incongruence was invariably put at the door of university educators. As one student commented:

> *'I don't think there has been enough clinical-lecturer support in the clinical area. I haven't seen my personal lecturer the whole 18 months. The other day, there was a personal tutor who was out there educating the nursing students in the environment. And I thought "Oh, that's wonderful" and I thought "I'd love that, if they came and spent time with a group of us on the wards and went over issues on the ward."'*
>
> (Student, discussion group)

Macy, a community midwife, felt that theory-practice links were not well managed:

**Macy:** *'They are not managed at all. It is ridiculous. I wonder how they learn anything.'*

**Interviewer:** *'Do students express this to you?'*

185

> M: *'Not only do they express it, we see it. By the time they do get used to something or begin to learn they are moved. So I don't think the timing is always right at their placements.'*

The view that more was learnt in the practice environment was clearly expressed by an 18-month student fairly new to the programme:

> *'You learn a lot on placements but as for the college work I still think … some of it is airy-fairy and irrelevant. Sometimes I just think it's a whole waste of time and the time would be better spent here.'* (Jenny, student)

There is an obvious issue connected to wider debates concerning the placing of nursing and midwifery education within higher education. Of relevance to educational practice, is the potential need for the value of classroom learning to be better communicated to students. This may be achieved by midwifery specialist educators explicitly ensuring that wider sociological material is grounded in its consequences for midwifery. However, in general terms, this challenge goes beyond the immediate issue of the preparation of midwives in relation to the provision of care to disadvantaged groups.

#### 8.3.3.3 Practice placements

As stated above, most participants gave much credence to the importance of practice placements. Furthermore, unlike in this case site, all students had access to disadvantaged service users in placements. However, practice placements were not without problems. In particular, the issue of mentorship was a major difficulty.

Rhoda, a midwifery manager, found that she often did not have enough midwives to mentor the students allocated to her area. Charlotte, a community midwife, reinforced this point. She suggested that mentors were not always able to 'teach' students but rather tended to use them as extra pairs of hands, which would limit both the quantity and quality of their learning:

> *'It is a very short staffed, very busy unit. [Students] don't want to come because they know that they are going to have to work bloody hard … If a midwife is allocated a student midwife, it is usually "Oh god" because of the extra work commitment that you take. Even that is changing in as much as, "Oh god, well that is good because she'll be able to give me a hand." So it is changing but not to the needs of the student, to the needs of the service really.'* (Charlotte, community midwife)

Students also believed they were not receiving sufficient support in clinical placements, although, as one student suggested, they were aware that this was largely because of other demands on their mentors.

Students talked about learning from other professionals in the practice arena, in particular doctors. However, it was interesting to note that, although health advocates had some formal input in classroom teaching, no participants mentioned work with the advocacy service as a formal route to learning. In this regard one student in the discussion group, who had just completed a nine-month placement in the trust where the research was undertaken, was unaware of the advocacy service. She even lamented the lack of such a service given the number of non-English speakers in the trust! Another student, who was also on placement in this trust, put her right:

> *'I think it's under-utilised but we do have an advocacy service … but it's not used as well as it is in [another hospital]. We tend not to get someone if you can just get by. The midwife will tend to say "You know what I'm saying", so the communication is minimised. We can get an advocate, we just tend not to pull on the resources.'* (Student 3, discussion group)

This discussion reflects the vagaries of mentorship, which ultimately depends on the way in which individual midwives work; in this case whether they used the advocacy service. Given the many complexities in the relationships between midwives and advocates, it seems imperative that contact with advocates be prioritised for students. This would give them an opportunity to learn the important, and challenging, skill of working with a third party in this way.

Asked whether practice placements were organised to give specific experience of different needs in midwifery, Gayle, an educator, responded in terms of balancing the 'high-tech' and the less 'high-tech' births but did not mention inequalities issues specifically. Since, in this case site, all students would gain experience of inequalities because of the local environment, this may have not been perceived as an issue needing to be addressed. Furthermore, many participants stated that the unit which was the focus of our study was a good place to gain experience of normal deliveries; an interesting advantage of being under-resourced and, as a result, having a relatively low level of technology.

As well as giving their own students access to disadvantaged service users, June, a midwifery manager, talked about the fact that some students from outside the area requested a placement in this case site to gain experience of working with ethnic minorities. However, in her experience, such students did not often stay long as they found the *'demands of the local community too much for them'*. Dealing with the 'demands' of the local population in this case site clearly required great skill.

### 8.3.3.4 Reflection

Although no classroom teaching sessions in which reflection was incorporated were observed, participants clearly felt that this was an important aspect of teaching and learning. However, very few specifically related reflection to the teaching and learning about inequalities. A senior educator talked about the use of the reflective diary on the three-year programme. She stated that students were invited to critically reflect on things and added that:

> *'Some of them pick up on it beautifully and others as you can imagine just don't ever, they fudge around the issue.'* (Sarah, senior educator)

An educator also spoke about the use of written reflection on the programme:

> *'We do encourage reflection … They're mostly formative, the reflective essays, but the students have found that they have grown a lot through them. I think that's good to hear. I think if you can get a reflective practitioner, they will stay reflective.'* (Gayle, educator)

Although not specifically framed as reflection, Gayle outlined how students were challenged in class to think about their values and attitudes, and how these specifically impacted on issues of inequality:

> *'We run a module on values in midwifery on the old curriculum and that's run by my colleague … When I talk about it in recruitment, I say it challenges all our students. Initially, I don't think they necessarily enjoy the module, they can't see its relationship to practice. There are lots of things in it, it's not just values, there's law, society, supervision … But what we encourage them to do is look at their own value system in order to understand how they then approach other people. The assessment is geared around care for a person and looking at the strengths and limitations, the inequalities that might be happening. For example, if a woman has had eight terminations of pregnancy and is now in because she is threatening to abort and sitting on the ante-natal ward … You often hear people make value statements like "Well, what does she suppose when she's had eight terminations in the past?" or "Typical Nigerian" …*

> *value-laden statements. Now where does that come from and what gives them the right really to do that and what happens to the care that they give to this woman as a result? So this course will directly challenge them to look at such a scenario and how they might be.'* (Gayle, educator)

Students coming to the end of the 18-month programme talked about the use of reflection on their programme. They commented that they had used *'quite a lot of reflective essays'* but that in class, reflection was more informal. None specifically mentioned reflection in the context of inequalities, although at other points in their interviews they drew attention to the importance of thinking about values and attitudes. Students, in general, were of the opinion that their most useful reflective episodes occurred whilst working with their mentors in the practice environment. For example, Jodie, a student near the beginning of the 18-month programme, talked about a positive experience, which had involved important input from her mentor, Macy, and a service user:

> *'One day I was trying to facilitate breastfeeding … and the lady said she was having problems and Macy said to me, "OK, Jodie, go and help her." So Macy started off by telling her to put the baby to the breast, which she did and she then said to me, "Is the baby on the breast properly?" and I said "No". So then I just went to her, "This is how you do blah blah" and Macy said to me, "Jodie, wait a minute, you need to find out what your client knows first. Then you go on from there". I was then able when I came out of that client's place to reflect back and think, "Yes, she actually knew what she was doing. Yes, I started to teach her and I could have taught her something totally new and confused her." Her baby was latched on properly, I didn't even need to teach her anything like that … and from that incident, each time I go to a woman now, it always flashes across my mind for me to assess and see; find out what your client knows first. Funnily enough, that particular incident really sort of, you know, I don't know if it is a milestone in my training. But I think it is something I will always use, I will always remember it … Afterwards I talked it through with Macy. Most days I was able to do that with her.'* (Jodie, student)

Jodie compared her experience with this mentor to experiences with the midwives on the ante-natal clinic. Here, she received little feedback, which she felt she needed:

> *'Now I am on ante-natal clinic and I do a history or a follow-up and I will say to them, "OK, what do you think I could have done better?" or "How could I have done this?" and I'll get "Oh no, that was fine." I don't know if that is because they are busy or I don't know, I suppose everybody is different but I find, with me, I need to reflect in order for me to learn. Reflecting really facilitates my learning …'* (Jodie, student)

Thus, comments regarding the value of reflection in this site were most frequently levied at practice, with students mentioning that their learning was greatly facilitated by reflection in this context.

#### 8.3.3.5 The assessment of understanding of inequalities issues

As in Case Site A and B, there was little in Case Site C that constituted a compulsory assessment of issues relating directly to inequalities. This was the case in both the practice and university contexts. For example, June, a midwifery manager, stated clearly that students did not have to address issues of disadvantage directly in practice assessments but felt that, working in this area, they *'would get a very good grounding in disadvantage'*. Rhoda, a midwifery manager, agreed. She stated that students were not assessed on inequalities issues but on issues concerning *'the social environment as a whole'*. It is worth noting that managers at Case Site C seemed more informed regarding the content and nature of practice assessments than their counterparts at Case Sites A and B.

On the practice-based assessment, Sarah, a senior educator, thought that inequalities issues were *'not central'* but *'come up fairly often'*. She talked about the joint assessment of practice and explained how the practice mentor assessed competence and university lecturers assessed the quality of the evidence students produced to support their practice. Although, she was not talking explicitly about inequalities issues at this point, it would be easy to see how inequalities issues could be assessed more formally in this way.

Sarah also spoke about assessment on the three-year programme. As with other case sites, it seemed that the assessment of students' understanding of inequalities issues was not explicitly mentioned in the assessment criteria:

> **Interviewer:** *'Can I just ask you a bit about how a student's theoretical assessments around inequalities and issues of disadvantage are formally assessed?'*
>
> **Sarah:** *'In the first module they do, they have three assessments really, two of them are formative. The third assessment is a critical incidence analysis … they choose an incident and then they have to consider in some way what the woman's needs were in the situation. So we get back to this vague idea of women's needs … So, the answer to it is no, it doesn't explicitly ask them to do it but they may if they are sharp and pick it up.'*

Students coming to the end of their 18-month programme were asked if and how inequalities issues were assessed. Most answered 'No' to this question, but Student 6 qualified this and others joined in:

> **Student 6:** *'We have practice based assessments in the clinical areas which normally incorporate things like that.'*
>
> **Student 3:** *'That's right.'*
>
> **Student 6:** *'Culture and how we dealt with it.'*

Thus, as in the other case sites, despite the fact that inequalities were ubiquitous, participants mentioned little in the way of compulsory assessment of inequalities issues. However, observation and curriculum analysis suggests that even though no participants picked it out, there was one compulsory assignment. This was the problem-based learning assignment discussed earlier, based on a domestic violence trigger within a module.

## 8.4 Conclusion

This chapter explored the ways in which participants thought about issues of inequalities and disadvantage in Case Site C. It was clear that issues regarding language barriers and ethnicity were of over-arching significance in framing responses. The role of bilingual health advocates in working with many service users interviewed was highlighted. This issue, so prominent in Case Site C, was not a significant feature in Case Sites A and B given their relative lack of ethnic minority clients.

The type of knowledge, skills and attitudes midwives need to develop in order to care for disadvantaged women was considered. Unlike in Case Sites A and B, there was a clear emphasis on the importance of knowing about non-western cultural norms and practices. A clear sense of the restricted role of the midwife in relation to tackling inequalities was emphasised, and this came across in all case sites.

The final section specifically addressed educational provision in relation to teaching and learning about inequality. Inequalities issues permeated the curriculum to some extent. Issues that arose in the classroom context and in practice were explored. The fact that practice placements were invariably in areas of deprivation was identified, as was the high value that many participants placed on learning in the practice context. Finally, the fact that, as in Case Sites A and B, there was no clear imperative in this case site for students to be assessed on issues of inequality was explored.

As in Case Sites A and B, there was much of note in the programme content which addressed issues of disadvantage and inequalities. However, the lack of follow-through from programme and module aims and outcomes statements to assessment was a weakness in all three case sites. This is raised again in the Chapter 9, which considers the developmental implications of this and other findings.

# CONCLUSION AND DEVELOPMENTAL IMPLICATIONS

## Key Points

- This chapter provides a summary of current education provision in relation to the preparation of midwives to meet the needs of disadvantaged clients, based on the empirical research within this project. Current practice across the case sites is compared and contrasted.
- It offers the concept of an 'inequalities imagination' as a broad, inclusive and creative conceptual tool within which midwifery educational innovations might be introduced and evaluated.
- The notion of developing an inequalities imagination both draws on, and moves beyond, notions of anti-discriminatory, anti-oppressive and culturally safe practice developed within social work, nursing and midwifery. Thus it offers a less prescriptive approach to working with disadvantaged clients.
- Educational preparation is reviewed within the sub-headings of curriculum design and planning, curriculum content, methods of educational delivery, assessment and who delivers? Curriculum content is further sub-divided into sections focusing on the knowledge of disadvantaged women's lives, attitudes and communication, and the role of the midwife.
- A variety of stakeholders were generally consulted on curriculum design and planning. However, there was a noticeable gap in the involvement of users, particularly from disadvantaged groups.
- The majority of curriculum philosophies examined made statements relating to issues of inequality. However, there was little evidence of those statements being systematically followed through to assessment.
- The research has demonstrated that there is a significant amount of material that aims to address students' understandings of the social/cultural context of disadvantaged women's lives. However, some students, particularly at Case Sites A and B, considered the front-loading of the sociology module frustrating. It is not entirely clear whether these concerns were an inevitable consequence of the educational process or the result of inappropriate programme design.
- The most commonly-cited client needs being addressed, within the curriculum analysis, were those concerning ethnic minority status, and substance misuse. Within midwifery education, women living in poverty did not appear to be addressed as a priority.
- There did not appear to be any direct correlation between students receiving input on a particular topic, and then being able to practise in a culturally-safe manner in relation to that issue.
- It appears that in order to maximise the chance of students becoming aware of, and sensitive to, inequalities issues, they need a broad exposure to disadvantaged clients within their practice placements.
- Most participants conceptualised the community as the arena most fitting to gain such experience, with midwives in the hospital sometimes being perceived as relatively unexposed to issues of disadvantage. There is great scope to develop the hospital arena as a learning environment for student midwives.
- The issues of attitudes and communication appear to be more important in the delivery of effective midwifery care to disadvantaged service users than the acquisition of knowledge of disadvantaged service users' lives. The use of reflection is key in this. Respondents reported that this was most effective when used in a structured way.

- **The contemporary context in both midwifery services and midwifery education presents both opportunities and threats to the development of an inequalities imagination in students and midwives.**

## 9.1 Introduction

This chapter draws on the empirical research to summarise the current position of midwifery education in relation to the preparation of midwives to meet the needs of disadvantaged clients. Practice across the case sites and institutions represented in the national survey is compared and contrasted in an attempt to draw out the developmental implications of the findings.

Below, the concept of an 'inequalities imagination' is introduced. This concept was developed as the research progressed, and we believe it provides a broad, inclusive and creative conceptual tool to stimulate reflection on the educational preparation of midwives to meet the needs of disadvantaged clients.

Drawing on this conceptual tool, the discussion is organised to review the educational preparation of midwives in both university and practice settings. This issue is examined under the following sub-headings:

- curriculum design and planning
- curriculum content
- methods of educational delivery
- assessment
- who delivers?

Curriculum content is further sub-divided into the following sections:

- knowledge of disadvantaged women's lives
- attitudes and communication
- the role of the midwife.

## 9.2 Developing an inequalities imagination: introducing the concept

This section aims to develop the idea of an inequalities imagination more fully, giving examples of why and how it can be applied in both education and practice settings and used to facilitate better links between the two. Before the application of this concept within the midwifery context is expanded upon, the meaning of the term 'imagination' is explored.

The *New Collins Dictionary* (1991) defines 'imagination' as:

1. *'The faculty or action of producing mental images of what is not present or has not been experienced.*
2. *'Mental creative ability.*
3. *'The ability to deal resourcefully with unexpected or unusual problems, circumstances etc.'*

We propose that imagination is defined as the use of a mental image to provoke, or enhance thought processes. However, the general nature of images is complex because although the user is sometimes aware of them and can easily describe them, they can also remain at a subconscious level, meaning that the user is not fully aware of their effect on thinking and behaviour. This complexity is compounded by the image being either an immediate response to an external stimulus linked to previous 'impressions' or one that emerges without an obvious external stimulus, and in both cases the image may be visual, auditory or kinaesthetic etc. in nature, sometimes incorporating an emotional element. Such diversity in the way that images are experienced makes it impossible to predict the exact outcome of their use, but the process of using them is more important.

Imagination is the result of the use of an image to provoke or enhance thought processes, or may be the actual thought processes relating to the use of an image. The nature of images in general is complex, not least because although the user can be aware of them and therefore easily describe them, they may also be subconscious and subject to a variable degree of awareness. They may be an immediate response to an external image linked to previous impressions which may be uni- or multi-sensory and include an emotional element, or one that emerges without an obvious external stimulus. Based on Aristotle's ideas, McMahon introduces the notion of images as motives and motivators: *'ancient theory (Aristotle) suggested that mental images of goal objects serve as motives by providing energisation and direction'* (McMahon, 1973: 465).

Our interpretation of the notion of imagination is along the lines of the above definition, and the importance of making explicit previously constructed images in order to expose, explore and guide current thinking and action is paramount. In an exploration of students' images of themselves as social workers, Gould and Harris suggest that *'initial images of a profession offer the novice a powerful frame in which to locate professional practice and behaviour'* (Gould and Harris, 1996: 234). Previously met role models from whom the practices and behaviours are remembered, were the basis for the students' image of the professional person they wished to be or not to be; this was often drawn from personal or a friend's experience. These images may be in line with current role models within particular professions, but Gould and Harris suggest that within the education process they are rarely addressed. This is despite the fact that research into teacher education shows that these frames of reference persist throughout the programme. Rigid images can reinforce previous blinkered thinking but, following Morgan (1993), we suggest that images and metaphors can be manipulated through (facilitated) reflective sessions. This is an important issue because, as Morgan also points out, these existing perspectives, assumptions, mind sets, life views and frames of reference lead people into seeing things in a particular way and then to repeat past behaviours. His advocated use of images and metaphors is aimed at getting people to think differently and potentially change their planned goals.

Mulligan (1992) takes this idea further, describing the use of imagination as a key not just to unlock the past but also to explore future behaviours internally without the risk of exposure to real-life consequences. The use of imagination is the precursor to creativity and action. Mulligan explains that imagination can help us transcend our normal everyday experience and envisage how things might be. It allows us to become someone else for a time and to see things from perspectives other than our own, and therefore can be a means of developing empathy (Mulligan, 1992: 185). This last characteristic is particularly important to the development of an inequalities imagination in those who have no direct experience of the particular disadvantage facing the client. This type of imagination process is equally important when a professional believes they have the gained empathy through experience of the same disadvantage. Although this aspect of their experience may be similar, other personal circumstances will be different and the client's situation is unique. In this sense, the notion of 'imagination' allows students and practitioners to harness creative resourcefulness, and it implies a loosening up of thinking, as explored more fully below.

In professional education, examples of the use of imagery and imagination are scarce, primarily because of the skill required to facilitate this type of activity. Furthermore, it is not always recognised in higher education as a learning skill, situated as it is within the realms of experiential learning. There is an inherent difficulty in measuring the outcome for this type of affective learning that does not fit neatly the categories of theory or practice as they are often currently defined and used in higher education.

Developing an inequalities imagination implies a shift in the discourse of contemporary midwifery education and practice. In particular, it implies developing a creative ability to move beyond the many dualisms that currently shape that discourse. Thus, it suggests a shift away from having to choose or prioritise between facts and experience, theory and practice, science/rationality and intuition/imagination, structure and agency and so on, to find a way of keeping both sides of this dualism in play at all times. Change and innovation are not simply rational processes, involving the implementation of tried and tested best practices. They are, as the term 'imagination' implies, much more creative.

The concept is also reminiscent of the notion of the 'sociological imagination' expounded by one of the founding fathers of sociology, Wright Mills (1959). However, whilst this concept was not drawn on explicitly in developing our concept of the inequalities imagination, such fundamental sociological ideas are undoubtedly embedded within the consciousness of some members of the research team. It is interesting to note that Wright Mills seemed to take for granted the meaning of imagination. However, he does offer a more general definition of *sociological* imagination:

> *'The sociological imagination enables its possessor to understand the larger historical scene in terms of its meaning for the inner life and the external career of a variety of individuals. It enables him [sic] to take into account how individuals, in the welter of their daily experience, often become falsely conscious of their social positions.'* (Wright Mills, 1959: 11)

Our interpretation of the concept 'imagination' also requires individuals to look beyond their immediate circumstances and develop a deeper understanding of themselves in relation to others. However, the emphasis on developing an inequalities imagination, encourages a commitment to thinking and acting creatively in relation to reducing the inequalities that persist between humans.

Central to midwifery students and midwives developing an inequalities imagination is an understanding of how the promotion of equality of care has been addressed in other disciplines, and the subsequent controversies that have arisen in relation to specific innovations such as anti-oppressive practice. However, talking about change in midwifery education and practice in terms of the development of an inequalities imagination moves us beyond the prescription to operationalise one particular framework such as cultural safety, anti-discriminatory or anti-oppressive practice. Each of these was developed in particular historical contexts and have produced their own controversies, which would be unhelpful to transpose directly to the midwifery context. Furthermore, both the notion of anti-oppressive practice and that of cultural safety were developed specifically in relation to issues of race and ethnicity. To simply expand their definition to include issues of inequality more broadly is not without its problems, as was seen in Chapter 3.

Unlike anti-discriminatory and anti-oppressive practices, which imply specific attitudes and behaviours that can be learnt, the concept of inequalities imagination recognises that no single set of practices will meet the needs of all disadvantaged clients. Instead, midwives need to learn and develop a set of generic skills and competencies, along the lines suggested by Gerrish et al. (1996) in their concept of 'inter-cultural competence', but also to acknowledge the importance of continually striving to become competent, rather than believing themselves to have become so (Campinha-Bacote, 1999).

The suggestion that midwives be required, and assisted, to develop an inequalities imagination draws heavily on this notion of intercultural competence. However, our research found that 'culture' and 'the cultural' were understood by most participants to refer only to issues related to ethnic minority clients or other issues related to race and racism. As our research brief was to examine the much broader constituency of 'disadvantaged women', we felt the need to develop a wider, more inclusive concept within which to explore and make specific recommendations.

Thus a key aspect of developing an inequalities imagination involves the development of a questioning approach to the subject of inequalities and disadvantage. For example, key concepts routinely used in midwifery education and practice could be interrogated for their meaning and their efficacy in relation to concrete situations. Examples here include 'individualised care', 'choice', 'control', 'needs' and 'empowerment'. Whilst in our empirical work there were many examples of such a questioning approach, we were surprised at how often these terms continued to be used without critique even in the university setting.

There are, of course, dangers in abandoning the prescriptive operationalisation of concepts already well established in other contexts. However, given that there seems to be no clear consensus regarding what anti-discriminatory or anti-oppressive practice might constitute in the nursing and midwifery context, it may be appropriate to employ a concept which is deliberately less prescriptive. Institutions or individuals purporting to act in a manner which is, for example, anti-discriminatory, may feel a sense of complacency which, on closer examination, is unwarranted. Our research evidence suggests there are many examples of curricula which use terms such as 'anti-discriminatory practice', 'anti-oppressive practice' in an ahistorical, unanalytical manner. In this, there is a sense of curricula promoting rhetoric rather than facilitating reflection on what these historically-specific concepts might mean for the future of midwifery practice.

This can also be said for some of the ways in which the rhetoric of individualised care was espoused in the case sites. However, as some research participants stated, individualised care is an ideal which should be aimed for. The concept of developing an inequalities imagination can complement the notion of individualised care so prevalent in midwifery education and practice. It implies thinking beyond a limited notion of individualised care (what the individual client says she wants or needs) to a more informed and creative approach that recognises the structural and individual factors that determine and define needs. Some community midwives in the study already showed this ability, often using their professional judgement, based on an understanding of the socially constructed nature of 'needs', to negotiate with the client and deliver what they feel to be appropriate care, even when it was not originally requested by the individual client. In order to be successful, this skilled activity requires understanding of self in relation to others, the use of empathy and sensitivity and an appropriate knowledge base.

This mix of skills is similar to the components described in Campinha-Bacote's (1999) model of the process of cultural competence. Whilst her exploration of cultural competence relates to race and ethnicity, the model has great relevance to the wider issues relating to disadvantaged clients and the process of developing an inequalities imagination.

Campinha-Bacote's model consists of five components: cultural awareness; cultural skill; cultural knowledge; cultural encounters and cultural desire, each of which is integral to the process of cultural competence. The findings of our study support the importance of these components. However, it is suggested that this cultural competence model best describes the development of competence in the one-to-one direct relationship between a midwife and an individual client. It does not explicitly recognise the practitioner's part in questioning the structural systems that perpetuate inequality. In this sense, Campinha-Bacote's model is anti-discriminatory, rather than anti-oppressive.

We have built on Campinha-Bacote's model, adapting and extending it to make more explicit the need to take a questioning approach not just to the care given to individuals but also to the systems of care delivery (see Figure 9.1). Furthermore, in some aspects of her model the emphasis on culture has been replaced with an emphasis on equalities; our understanding of the notion of 'culture' is broader than that of Campinha-Bacote, and goes beyond notions of ethnicity to include wider issues of difference.

195

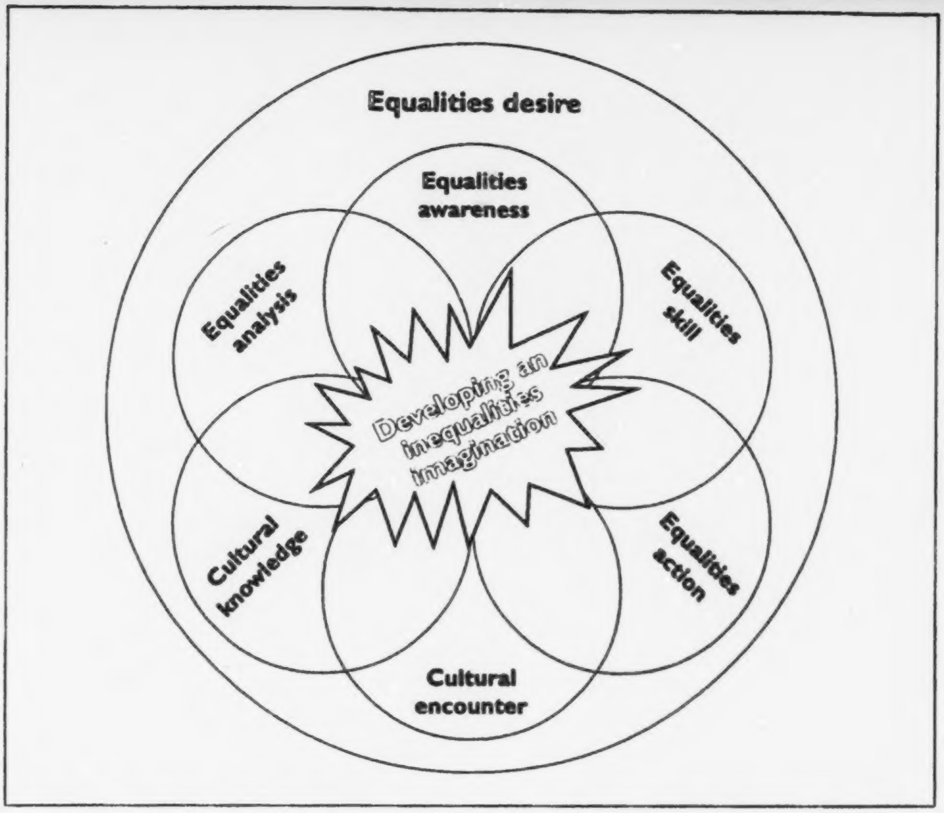

Figure 9.1: A model for developing an inequalities imagination

The description of the model begins with *(equalities) desire*, which is the most important component. This is represented as the will to develop competence which is based on *'caring which begins in the heart and not the mouth'* (Campinha-Bacote, 1999: 205). This is a significant part of the process involved in developing an inequalities imagination without which use of other parts of the model may result in 'politically correct' behaviour alone, rather than a genuine attempt to value and respect clients as people and demonstrating a commitment to reducing inequalities between them. *(Equalities) awareness* is constituted by the deliberate attempt to consider one's own personal history and then to look beyond one's immediate circumstances and gain a deeper awareness of self in relation to others. This involves examining self and exposing one's biases and prejudices as far as one is able to. As in Campinha-Bacote's model we see *(cultural) knowledge* as the process of seeking and obtaining a sound educational foundation for understanding the world view of others, but also the acquisition of knowledge about epidemiological, biological and psychological aspects specific to the client or client group. This information is necessary to enable *(equalities) skill* in collecting appropriate information about the client in order to undertake assessment and plan to deliver appropriate care. *(Cultural) encounter* depends on exposure to a diverse range of clients which enables the continual rehearsal and improvement of equalities skills together with a renewed opportunity to examine ones *(equalities)* awareness/perspective. As Campinha-Bacote points out, engaging in such encounters can be difficult and uncomfortable at times, as has been reported in this study. Continued encounters may not be possible for some students or practitioners depending on their geographic location, which may lead to loss of skills. In these cases, to some extent the skills may be refreshed and/or regained by the type of mental imagery training discussed later in this chapter (Backman, 1997). A further component introduced within the model is that of *(equalities) analysis*, which represents the development of a questioning approach to the social construction of disadvantage and its relationship to the ways in which the structure of maternity delivery systems reinforce inequalities. The final component that completes this model of the process of developing an inequalities imagination is the notion of *(equalities) action.* This incorporates the notion that a student, lecturer or practitioner engages in actual activity which should lead to challenging inequalities, although there is flexibility within the model with regard to what such action will consist of; what might be appropriate for a midwifery manager, might not be appropriate for a pre-registration student.

The model then encompasses biological, psychological, and sociological dimensions across cognitive and affective domains in order to describe the components necessary to the development of an inequalities imagination. However, it is important to stress that the model is seen as a striving towards continued development of this imagination, rather than expecting that it is possible to have a complete inequalities imagination. Here development rather than accomplishment is emphasised because no matter how experienced practitioners become, the uniqueness of service users with their individual constellations of disadvantage require them to constantly re-evaluate their thinking and behaviour. However, the greater the expertise in the component parts the greater and more expansive the imagination becomes. Thus this is a model of striving to develop rather than one of having developed an inequalities imagination. Furthermore, individuals may develop different aspects of the model at different rates, hence the jagged edges within the centre.

Despite claims in curriculum philosophies that students are taught to practice in anti-discriminatory or anti-oppressive ways, our research suggests that this is an unrealistic expectation to place on pre-registration students, who are still coming to terms with basic clinical competencies. Thus the notion of requiring both student and qualified midwives to develop an inequalities imagination is, in some senses, less ambitious than asking them to implement anti-discriminatory or anti-oppressive practice, both problematic concepts, in themselves. The inequalities imagination concept recognises that change is a gradual, ongoing, developmental process. It offers an opportunity for some success, a chance to 'get something right' as well as a chance to reflect on and assess how things might have been done differently.

Getting something right is important, given that our research clearly confirmed that resource constraints and organisational culture often engender apathy amongst midwives. Employing the concept of the inequalities imagination here can help prevent the kind of defensiveness and stasis to which Gerrish at al. (1996) refer:

> *'Regrettably, some institutions will invoke the unfortunate circumstances of the times, and their curriculum bursting at its seams, to resist such demands [to address the needs of minority ethnic clients]. And of course, this line of resistance is all the more effective because it may be argued in the apparently reasonable discourse of resources and timetables. Hostility to the innovation in itself may never need to be declared. More sophisticated variants on this theme involve invoking the general fraught scenario, and then placing oneself and one's institution into a position of self-declared virtue by outlining an existing "progressive" commitment. Whether it be in the area of disability, women's health or whatever, the implied claim is "we have done our bit, ticked that box, we cannot reasonably be expected to do everything". This is a strategy that is all the more powerful because not only may it serve as management rhetoric, it may also find support as a comforting crutch to individual staff who feel they cannot be expected to address yet another professional requirement. It then becomes a position that has institutional legitimacy.'*
>
> (Gerrish et al., 1996: 127-128)

A similar problem arises with the requirement that midwives learn to be non-judgemental. This was found to be a common requirement across all curricula, and yet one that was impossible to achieve. Part of the problem was that, whilst curriculum analysis showed that self-awareness was identified as the second most important attitude to be developed, there were

197

few examples of good practice in developing this self-awareness. In addition, there was little articulation of the link between the development of a non-judgemental attitude and self-awareness, yet it is clear that the former cannot begin to be worked towards without the latter. We found little appreciation of the fact that acquiring a non-judgemental attitude was an unrealisable ideal, given that thoughts and actions take place in the context of specific personal and professional histories. Furthermore, the issue of unconscious reactions was not raised in this regard. Thus, a great deal of rhetoric about the importance of being non-judgemental was found, alongside examples and reports of explicit or barely-disguised prejudice amongst students and qualified midwives that colleagues felt unable to challenge.

In this situation, it was hard to see how attitudes would change, since few participants were able to 'own' prejudicial attitudes and/or behaviours. By contrast, inequalities imagination, with its emphasis on the imagination, implies a 'loosening up' that would enable midwives to acknowledge the effects of personal and professional histories on attitudes and behaviours. Thus the difficulties involved in working with clients with whom they may have little empathy or sympathy could be acknowledged. It also offers a chance for students and midwives alike to contribute ideas and suggestions for changes in practice based on their own experiences, fears and ideals, and have them taken seriously by colleagues and peers. These suggestions imply a greater role for the process of reflection in midwifery education. However, some may see the above as somewhat idealistic and requiring a high level of mutual trust amongst colleagues, as is seen in collaborative teamworking (Miller et al., 1999). Therefore, we need to acknowledge that the realities of working within the NHS environment may militate against this suggested way of working.

As our research has shown, most participants recognise the importance of midwives reflecting on their practice. However, there was a great deal of variation in how far, and in what ways, this process was implemented in different curricula. Developing an inequalities imagination implies thinking more creatively about this reflection process. In particular, it seems that this should be an ongoing process engaged in by students, midwives and lecturers alike. There is potential for reflection to occur both in peer group settings and during the supervisory process. Some may argue that they already undertake this level of reflection. However, if this is the case a clear mechanism should be developed for its demonstration.

Overall, the concept of developing an inequalities imagination provides a potentially useful tool with which to think about how midwifery education might be improved to enable midwives to meet the needs of disadvantaged clients more fully. It is easy to become locked into established ways of doing things and to neglect potentially useful ideas and initiatives that do not immediately fit with overall philosophy or existing practices. Of course, the proliferation of guidelines and protocols for clinical effectiveness may seriously inhibit professionals from fully realising such an imaginative way of working.

It is clear from our research that 'inequalities' is not a straightforward concept or problem that can simply be taught about/learned about via the acquisition of facts. It involves a complex interaction between facts, theory, experience, beliefs, values and resources, and is a long-term, ongoing process of knowledge acquisition, experience via practice and reflection that occurs through processes of both formal and informal learning. Midwives need to develop this inequalities imagination in order to deliver equality of care to all women, to bridge the gap between what they face, complex constellations of disadvantage and where they are 'at'; that is, their individual and collective starting points. The following sections examine where and how the midwifery curriculum can be improved to facilitate this process amongst the various stakeholders in midwifery education and practice.

## 9.3 Curriculum design and planning

Appropriate curriculum design and planning is an important step on the path towards students developing an inequalities imagination. Questionnaire data and evidence from the case sites suggest that a relatively wide variety of stakeholders are generally consulted and have input into curriculum design and planning. Whilst, as might be expected, the majority of stakeholders are midwifery educators, planning teams are, to some extent, made up of individuals from very different disciplinary contexts who do not necessarily share the same philosophical frameworks. It is unlikely that all members of planning teams will embrace the acquisition of the type of inequalities imagination explored above. Furthermore, the reality of attempting to include more subjects in an already crowded curriculum needs to be acknowledged.

It follows that, for inequalities issues to be fully addressed, they will need a champion at the design and planning stage, even within the current climate of mandates from central Government. Individuals with appropriate expertise should therefore be included on planning teams to promote the allocation of space and time for specific input on inequalities issues. Furthermore, this individual could also advocate for reflection on how different aspects of the curriculum contribute towards, or in some cases detract from, students' understanding of inequalities issues.

In the questionnaire data, only a third of respondents reported representatives from sociology departments being on planning teams, a surprisingly low number given the teaching input from sociologists across the programmes surveyed. This point is discussed later when curriculum content and the need for closer collaboration in the context of interdisciplinary programme teams are considered.

Another potentially valuable way in which midwifery educators who design curricula can be facilitated to address inequalities issues is to include users and/or user representatives on planning teams. There is clear evidence, from both the curriculum questionnaires and case site analyses, of service user input to programme planning. Approximately half of the survey respondents reported user representation on the planning team. This is unsurprising given that midwifery took the lead in the context of nursing and midwifery education in having non-professionals on planning groups. However, no respondents reported representation from disadvantaged service users.

User involvement at this level is not without its problems, with issues of representation, and power differentials between professionals and clients, of particular relevance. Given the breadth of service-user identities to which the concept of disadvantage can be applied, it would be impossible to find one or two users or representatives to cover such a wide range of constituents. The degree to which individuals can generalise from and reflect analytically on their personal experience is also relevant. Furthermore, in some cases, individuals who experience complex constellations of disadvantage may be the least likely to feel comfortable in a curriculum design and planning meeting. There is also the danger that power relationships prevalent in the practice arena are simply reproduced in planning teams. As a start, planning teams incorporating users might reflect on whether or not they are paid for their time and reimbursed for their expenses.

Notwithstanding these problems, it is important to include some specialist input in relation to inequalities in health from the user perspective. We faced these issues when attempting to include user perspectives in the steering group for our study. The services of colleagues working directly with disadvantaged clients in other health arenas within the voluntary sector were drawn upon. Although this was not a perfect solution it greatly enriched the advice generated by the steering group.

Another issue for those involved in curriculum design and planning is when and where to place inequalities issues in the curriculum. For some students, particularly in Case Site C where all students interviewed were on the 18-month programme, there was resistance to current teaching and learning about inequalities issues. Some of their concerns were mirrored in Case Sites A and B. Competing demands on their time, particularly in relation to obtaining clinical skills, were frequently mentioned and students felt that given time constraints, and the fact that they had undergone previous training, generic sociology was misplaced. Furthermore, many on the three-year programmes initially found the front-loading of sociology frustrating, and struggled to appreciate its relevance. However, retrospectively, some understood the value of introductory work on the broad, theoretical bases of inequalities.

The salience of particular topics to students is important to consider. At the feedback session in Case Site B, an educator indicated that they were reviewing the placing of sociology and health policy in the curriculum. Nationally, it may be appropriate to review the placing and delivery of such material. It is clear that students in the study would have appreciated a more specific sense of its relationship to midwifery practice, from the beginning of their programmes. Some might argue that these feelings are an inevitable consequence of the educational process, and are not a result of inappropriate programme design; on the other hand, this may be perceived as an excuse for educators to eschew undertaking a critical review of their teaching and curriculum design.

Regardless of the placing of generic modules, a midwifery lecturer with a good understanding of the application of inequalities to midwifery practice can facilitate students to understand the application of this material to practice early in the programme. This would encourage students to place inequalities issues firmly within the professional remit of practice from the start of their midwifery preparation.

### 9.3.1 Developmental implications

The developmental implications of the findings regarding curriculum design and planning are as follows:

- there should be a 'champion' on inequalities issues in the curriculum design and planning team
- representatives with a sociology disciplinary background should be on curriculum design and planning teams
- greater involvement of disadvantaged service users and representatives is needed in curriculum design and planning
- the placing and timing of broad sociological/social policy modules used to introduce inequalities issues should be reviewed
- a midwifery lecturer should take responsibility for facilitating students to understand the links between generic inequalities and midwifery practice from the beginning of the programme.

## 9.4 Curriculum content

Most curriculum philosophies surveyed, at both pre- and post-registration levels, made statements which related to issues of inequality. However, there was little evidence of these broad philosophical statements being systematically followed through to assessment. Nevertheless, it was clear that curriculum philosophies went a long way to form the basis from which curriculum content was generated. This section explores the issue of curriculum content. From the national survey data, what is currently included in the curricula is considered. Then, drawing on the case site analyses, the contemporary reality regarding the kinds of issues about which students learn, and what they might need to learn, in both practice and university settings in order to give appropriate care to disadvantaged women is explored. The discussion is organised under the following headings:

- knowledge of disadvantaged women's lives
- attitudes and communication
- the role of the midwife.

### 9.4.1 Knowledge of disadvantaged women's lives

The types of knowledge about disadvantaged women's lives that arose as important in our study are discussed in the university setting and then in the practice setting.

#### 9.4.1.1 The university setting

Overall, the evidence suggests that there is a clear commitment within the educational environment from both lecturers and students to promoting equality of care. Evidence from all three case sites and from curriculum analysis suggests that there is much within midwifery education that aims to address students' understanding of the social/cultural context of disadvantaged women's lives. Much of this was covered in dedicated sociology and social policy modules or sessions and/or sessions concerned with women's lives.

It was clear from our study that teaching about disadvantage and inequality potentially covers an enormous range of conceptual issues and possible client groups. We were therefore impressed by the breadth of coverage regarding disadvantage at both structural and individual levels. Curriculum analysis provides relevant evidence here, although it should be noted that the over-representation of some institutions means that the figures should be interpreted loosely. The most commonly cited client needs addressed were those concerning ethnic minority status and substance abuse. Physical disabilities, women who had suffered abuse and teenage parenting were the next most frequently cited. Lower down the list came women living in poverty. This is perhaps surprising, as in the case sites, this issue was one of the most frequently mentioned in relation to practice, along with ethnic minority issues. A large proportion of client referrals from midwives for our study were women living in relative poverty. Also, given the relationship between poverty and low birth weight, this issue has important implications for health outcomes for mothers and babies. If, as the questionnaire data indicate, women living in poverty are not addressed as a priority at a national level in midwifery education, this is an area where there is room for improvement.

When asked if there were any client needs which they did not address, only seven respondents drew attention to particular groups: travellers; some minority groups; single unsupported mothers; lesbian mothers; specific disabled women; and the elderly. However, it was invariably in the context of having compiled a lengthy list of those who were.

Despite the fact that there is evidence to suggest that the needs of disadvantaged clients were broadly addressed, the precise extent and the degree to which they were related to midwifery practice is in question. There is not necessarily any direct correlation between students receiving input on a particular topic and them being able to practice in a culturally safe manner in relation to that issue. There may be several different inhibiting factors here. For example, students might be taught 'ideal' practice in a university context and find it difficult to put into practice because of service constraints. A typical example of this from the case sites was the issue of access to, and use of, interpreting services. Students complained that whilst they had been taught the importance of using advocates and/or interpreters, in practice they had no access to them or felt discouraged from using them. Students may also receive input from speakers who are not themselves working in any sense towards developing an inequalities imagination. The episode relating to the teaching of ante-natal screening in Case Site A is the most obvious illustration of this point.

Teaching students about services available is also relevant to this discussion of the precise nature of curriculum content in relation to disadvantaged service users. Thinking through the precise role of the midwife within multiprofessional teams is important here, especially given the proliferation of services in both the statutory and voluntary sector aimed at supporting disadvantaged service users. In order to achieve this, a teaching and learning package specific to the local area could be developed. This would include information concerning local inequalities and local resources available to service users and midwives in both the statutory and voluntary sectors. It would be appropriate for this to be a compulsory part of pre-registration education.

This issue of local inequalities is also relevant in post-registration education. For instance, if a midwife working at Case Site A were to relocate to Case Site C, she would find herself working with very different service users and within a different midwifery culture. In view of this, service providers could develop a similar teaching and learning package to that discussed above, as an effective induction for newly-contracted midwives.

#### 9.4.1.2 The practice setting

Across the case sites, the view was consistently put forward that much of the content students needed to learn regarding inequalities and disadvantage could be acquired in practice placements. However, it would be necessary for students to have appropriate practice placements. Whilst most educators mentioned this, few felt that placements within an area of socio-economic disadvantage should be compulsory. Most primarily thought about this by focusing on issues such as transportation, travel time, limited financial resources, preceptor continuity etc. This student-centred approach was instigated possibly at the expense of students' need for practice placements that gave them experience of clients with constellations of disadvantage.

Gerrish et al. (1996) called for compulsory placements in areas of significant ethnic minority population. In the current educational climate, we are reluctant to make a similar recommendation in relation to disadvantaged clients more broadly, due to the concerns of both educators and students in the study, regarding demands on students. However, the lesson seems to be that in order for students to have a chance of developing an inequalities imagination, they need to be exposed to disadvantage in the community. The allocation or placement process therefore needs to have this taken into consideration, alongside other matters such as preceptor continuity, proximity to students' homes, and students' limited financial resources. Such an expectation should be explicit in the agreement between both providers, i.e. education and service. If this is an impossible equation, students should be enabled/encouraged to swap with their colleagues, even for a limited period, in order to gain relevant experience. This practice was instigated by two students in Case Site B and was reported by both students and tutors to have been beneficial. Again, this involves an imaginative leap to overcome resource and other constraints.

However, students in some placements could benefit from broader exposure to disadvantaged clients. One example of how this might be managed is to make greater use of visits to projects dedicated to ameliorating the health of disadvantaged service users. One reservation here is that it should be ensured that students do not overwhelm such projects. Attention needs to paid to the phenomenon of disadvantaged service users being inundated with students needing to learn from them. Issues of continuity of care(r) and the gratuitous involvement of professionals in service users' lives are also relevant here. For example, in Case Site C all students were required to focus on the same issue (domestic violence) for their problem-based learning topic. This may have resulted in unnecessary strain on both library and community services.

Given the limitations regarding the organisation of community placements, perhaps more explicit emphasis should be placed on using the hospital arena as a learning environment, since all students will experience a hospital placement, and most clients will come into the hospital. In Case Site A, three participants drew attention to the fact that practice placements on a ward for women who required more input, such as those with learning difficulties, drug users, etc. gave them considerable experience of working with disadvantaged clients. On the whole, however, most described the community as the arena in which it was most fitting to gain such experience. Midwives in the hospital were sometimes perceived to be relatively unexposed and disengaged with the complex issues of disadvantage. Furthermore, some of the strongest complaints from clients were directed at hospital midwives, with the issue of unfriendliness coming out very starkly.

There is scope to reconsider the balance between community and hospital as learning environments in which to develop understandings of disadvantaged women's lives. Educators should encourage students to think of both arenas as learning environments, recognising that different challenges exist in each in relation to disadvantage.

#### 9.4.1.3 Developmental implications

The developmental implications regarding knowledge of disadvantaged women's lives are as follows:

- more theoretical input is required on women living in poverty to match client group need
- experiential knowledge of working with disadvantaged clients should be made compulsory.

Imaginative ways of overcoming resource constraints implied by the latter suggestion include:

- swapping of placements between students
- student visits to projects dedicated to specific client groups
- making more use of disadvantaged clients in classroom learning
- making more use of the hospital placements as learning environments, especially where there are dedicated wards for specific client groups
- development of a teaching and learning package relating to service provision for disadvantaged service users in the local context
- use of this teaching and learning package with all pre-registration students
- development of a similar package as part of induction for all newly contracted midwives.

### 9.4.2 Attitudes and communication

Earlier in this chapter, it was suggested that one of the major challenges involved in developing an inequalities imagination is for practitioners to become attuned to the way in which their own lifestyles and identities affect how they work with clients. Midwives often face additional challenges in working with disadvantaged clients because such clients' lifestyles and experiences often challenge hegemonic (dominant) discourses of reproduction and parenthood within which midwifery culture is largely embedded. Midwives working within the dominant culture may not be fully aware that this is the case. Many midwives in the study clearly worked with an implicit notion of 'normal families' and 'nice ladies', who were generally articulate and embracing of midwives' input. Such individuals were thought to be relatively well-educated, white, married, middle-class, breastfeeding women. Thus, clients not fitting this description were necessarily perceived as 'other', sometimes deserving, sometimes not. The midwife participants interviewed did not always seem to be aware that they constructed their clients in this way. This was particularly so in Case Site A and to some extent in Case Site B. Even at Case Site C, where the majority of clients experienced constellations of disadvantage, many students and midwives ascribed to a hegemonic notion of 'normal, nice, ladies', clearly emphasising their clients' difference.

However, there was some evidence that individual midwives sometimes challenged hegemonic constructions of reproduction and parenthood. This occurred most often in relation to younger mothers. For example, in Case Site B, a midwifery manager emphasised the socially constructed nature of teenage motherhood. In Case Site C, the challenges brought to dominant discourses of reproduction and parenting by the attitudes and practices of many ethnic minority clients, and those who cared for them, is a further illustration.

Nevertheless, whilst midwives did challenge hegemonic discourse, the very same midwives sometimes revealed ways in which some of their own beliefs and actions were largely embedded within such dominant cultural 'norms'. This is evidence to the fact that the nature of human beings is such that we act in ways that are often contradictory. We do not always act with one set of integrated beliefs as 'unitary persons', expressing ourselves solely through one set of beliefs or one cultural discourse. There is scope then, within midwifery education for students and lecturers to be facilitated towards an understanding of the possibly contradictory ways in which they construct client identities in relation to dominant identities and how this affects their practice. Here, the need for reflection and self-awareness with regard to communication with disadvantaged clients is crucial.

Thus, it seems that, in some ways, issues of attitudes and communication are even more important in the delivery of effective midwifery care to disadvantaged service users, than is the acquisition of knowledge of disadvantaged services users' lives. Working on these issues is an essential part of developing an inequalities imagination, because of the clearly enormous potential for unconscious psychological processes and cultural discourses to impact on practitioners' attitudes and behaviours. Further salience of this issue is evidenced by the fact that concerns about attitudes and communication were the most prominent feature of interviews with service users. Time and time again, users emphasised the importance of being treated in a friendly way. When asked to expand on their interpretation of friendliness, they emphasised being smiled at, being listened to, not being judged, and being treated with respect.

The findings on this issue corroborate other studies in this area (Hart et al., 1999; Kirkham 2000; Oakley, 1992). Given the overwhelming evidence of the importance to service users of these basic attributes amongst health professionals, midwifery education should ensure that all students are given ample opportunity to develop such skills. To be fully operationalised, such skills need to be imparted within a context that enables students to develop self-insight and an appreciation of how deeply human beings are embedded and socialised within a particular set of cultural values and norms. Thus, the task in the midwifery context is to help students tease out how their own values and attitudes affect their interaction with service users.

#### 9.4.2.1 Content in the classroom

There is some evidence within the study that student attitudes and communication skills were addressed in the university setting. In the pre-registration survey, a number of respondents reported that their curriculum highlighted issues of self-awareness and the development of a non-judgemental attitude. Evidence of this can also be found in the case site studies. For instance, at Case Site B, early in the three-year programme there was a module dedicated to communication and interpersonal skills. Furthermore, across the case sites, there was evidence of some interweaving of attitudes and communication skills development within sessions which explored aspects of disadvantaged women's lives. For example, in Case Site A, a session providing an historical overview of parenting, encouraged students to think beyond hegemonic assumptions about who was fit to parent.

Despite the above examples demonstrating that attitudes and communications issues were addressed to some degree, there was little evidence of students' views being challenged by lecturers. Setting up appropriate environments within which challenging may occur is of utmost importance in facilitating the development of an inequalities imagination. Ways in which this might be improved are explored in Section 10.5.

One of the ways in which attitudes and communication skills are taught is, of course, through reflective practice. There was ample evidence that programmes include opportunities for reflection on action. However, the way in which the concept was employed was often vague. Educators could usefully consider how they might structure reflective sessions more systematically. As students in Case Site A commented, the reflective sessions they found most helpful were ones that were well structured.

There was very little evidence of students receiving input regarding the development of basic midwifery communication skills which would encourage service users to change health-threatening behaviours. They were taught about the relatively high incidence of smoking and low levels of breastfeeding amongst socially disadvantaged service users, but little dynamic discussion, role play, exploration of change theory etc. that would enable students to operationalise their knowledge. One exception to this occurred at Case Site A, where the trust provided post-registration training on smoking cessation support. Unfortunately this session was poorly attended, possibly an illustration of the findings that, at Case Site A and, indeed, other sites, midwives felt there was little they could do to change people's behaviour. This response, although understandable in the light of midwifery workloads, is of considerable concern to issues of inequality. Given the links between, for example, breastfeeding and health benefits to mothers and babies, practical skills which enable students to promote breastfeeding to low income service users need to be prioritised. As discussed in relation to the case sites, midwives should be wary of forcing services on clients who clearly do not want them. However, it may be that, as with the implementation of ante-natal screening for HIV (Simpson et al., 1998), midwives may be reluctant to discuss certain issues, such as discussing breastfeeding with service users who do not readily embrace the practice. Whilst the reason given may be of not wanting to impose one's own values and beliefs on clients it may be as much to do with midwives' own attitudes and behaviours as those of their clients.

The lack of skills and confidence in dealing with potentially rejecting or confrontational behaviour is applicable here. The use of professional actors to work with students in the safety of the classroom setting might be worth exploring, and has already begun to be developed in the midwifery context elsewhere (Baker et al., 1997). Similar techniques have been used successfully in a variety of other contexts, such as mental imaging training used to prepare police trainees for stressful situations (Backman et al., 1997). They may be usefully drawn on to enhance the experiential nature of developing an inequalities imagination. Overall, little evidence of innovative teaching on attitudes and communication within the midwifery context was found.

### 9.4.2.2 Attitudes and communication in practice

It is often assumed that students learn appropriate attitudes and good communications skills in the practice arena, with preceptors playing a key role. This is understood within the context of an apprenticeship model in which the students shadow qualified midwives, then proceed to undertake practice supervised by them. This, of course, relies on a ready supply of suitably qualified preceptors. Whilst students in the case sites cited examples of positive role models, at times they learnt from their preceptors how they themselves might not want to practice. Adequate opportunity to reflect on action in the classroom setting would enable such students to explore further their feelings in relation to preceptor practice, whether perceived to be negative or positive.

Given this apprenticeship model, there was little evidence of the systematic teaching of these issues in practice, although when it came to assessment, this area was formally evaluated. Effective teaching of attitudinal issues and communication skills at pre-registration may depend on how these were covered in the preceptor's own preparation for the educational role. In Case Site A, there was evidence to suggest that issues such as anti-discriminatory practice were addressed. However, there is insufficient evidence to comment in more detail on the level achieved in this regard in post-registration preceptorship preparation, Teaching and Assessing in Clinical Practice for Midwives on Part 10 of the professional register (ENB 997).

The importance of appropriate preparation for preceptors is the subject of many recent studies within nursing and midwifery (Gerrish et al., 1997; Murphy, 2000; White et al., 1993). It is regrettable to report that the empirical data suggests that, in practice, many preceptors in our study had not actually studied for the ENB 997. Furthermore, preceptors were often hard to come by. It was sometimes more a case of finding any qualified midwife with whom a student could work than setting up continuity of preceptor who had qualified as an educator of midwives. This situation, which reflects the current national picture in nursing and midwifery (DoH 2000b; UKCC, 1999; Veitch et al., 1997), is clearly unacceptable and should be addressed. However, given the current situation, where reflection-in-action rarely takes place fully, it becomes even more incumbent on university lecturers to facilitate reflection-on-practice.

However, it seems clear that the preceptorship model of facilitating learning is worth getting right. Recent studies show that students greatly valued the learning achieved from appropriately prepared preceptors (Cope et al., 2000; Gray and Smith, 1999; Gerrish et al., 1996). In relation to the contexts within which the case site analyses took place, it is clear that the preceptorship model worked better in the community than the hospital context. In view of the findings regarding the relative merits of hospital and community preceptors, and the fact that service users reported less satisfaction with the care received in the hospital setting, preceptorship in the hospital context must be urgently addressed.

Students often referred to their community preceptors as having taught them much of what they knew about midwifery practice. The example from Case Site C, in which a student reflected on how her preceptor taught her how to operationalise what she had been taught in the classroom in the context of an interaction with a client, is an obvious one. Here, the preceptor encouraged the student to use her imagination and to think creatively about how to interact with this woman and find out what she already knew to support her in breastfeeding. This meant that the student was able to individualise what she had learnt in the classroom, rather than directly 'dumping' generalised, and sometimes inappropriate information, onto her interaction with the woman.

The needs and wants of disadvantaged clients are clearly relevant to all practising midwives, regardless of practice setting. However, such needs are not uniform and this diversity has important implications for how midwives need to develop their communications skills. Within the study, disadvantaged clients took one of the following positions:

- did not have explicit expectations of the service
- had expectations, but were not facilitated to communicate them, for example service users who experienced language barriers or those with a learning difficulty
- had expectations, but did not verbalise them to health professionals
- had expectations, tentatively discussed them, but did not pursue them if not affirmed by the midwife
- were satisfied with a very basic level of service; amongst ethnic minority service users at Case Site C this was often as a result of their own experiences of receiving, in other countries, seriously neglectful care or the total absence of care
- had very clear expectations and verbalised them.

Time needs to be spent on understanding not only individual clients' expectations, but how they come to be formulated, taking clients' socio-cultural background and life experiences into account. At times, it may be appropriate for midwives to raise clients' expectations of the health care to which they are entitled. Furthermore it is appropriate for midwives to aspire to informed choice for all clients, and this should not rely on the client being articulate and demanding. Thus the midwife's role is much greater than simply responding to clients' expressed needs or wants, which are explored further in the next section.

### 9.4.2.3 Developmental Implications

The developmental implications regarding attitudes and communication, are as follows:

- increased commitment is needed amongst all those in midwifery education and practice to developing self-awareness

- increased commitment to gaining skills in challenging attitudes of peers, colleagues and service users is needed
- methods for reflection on attitudes and communications skills should be improved by introducing more structured approaches to reflection that specifically aim to address disadvantaged clients and inequalities in health
- innovative methods to better equip midwives with skills and confidence to encourage service users to change health-threatening behaviours, e.g. use of actors for drama re-enactment should be developed
- all students should be provided with appropriately-qualified and updated preceptorship in both community and hospital settings.

### 9.4.3 The role of the midwife

In many ways, defining the role of the midwife in relation to working with disadvantaged clients has come to frame our research. If this role can be more clearly defined in relation to addressing inequalities, then it should be easier to define the educational preparation needed to fulfil this role.

However, this is a complex issue and there is a real tension between defining the role and allowing some flexibility within the role that, in turn, will enable the midwife to work in a creative manner. Whilst this flexibility is an essential ingredient in delivering individualised care and allowing the individual practitioner to think and plan creatively, it must not detract from a firm commitment to addressing inequalities. Therefore it must also be accompanied by a strong commitment, across the board, with an obvious management lead, to begin to tackle inequalities in health. This could be ensured by developing a unique combination of flexibility in the way the role is carried out accompanied by rigorous target-orientated aims, outcomes and practitioner accountability, in conjunction with strong leadership.

As the case site data showed, for some midwives and students, lack of clear definition of role in relation to inequalities issues causes some anxiety. Time and again, midwives expressed a clear need to understand precisely what their role should be in relation to working with disadvantaged clients; many were equally clear that this role must be limited in some way. This issue is especially important in the context of the recent move towards a more public health role for midwifery and the continuing recruitment and resource problems in the NHS. Students and midwives need to be better supported in coping with the changing role and potential flexibility of role explored above, to enable them to make best use of their unique profession.

Furthermore, as seen in the case sites, the culture of midwifery practice has not historically embraced public health and broader policy agendas, although it is perhaps beginning to now (Morris, 1999; Ollerhead, 1999). Whilst the maternity services manager in Case Site C was knowledgeable about recent policy directives, in another case site, one senior midwifery manager could not name a single health policy document relating to inequalities. This, of course, is likely to change in response to current Government initiatives.

The following sections explore how issues concerning the role of the midwife emerged in both university and practice settings, and make suggestions as to how this role could be made more explicit in both settings in relation to inequalities in health, and how the two areas can work together to make this role better understood by all.

#### 9.4.3.1 Exploring the role in the university setting

From the curriculum analysis, it is clear that the role of the midwife in relation to working with disadvantage clients, specifically, was rarely made explicit. Case site analyses show that midwives needed more guidance on this issue if they were to deliver appropriate care, know when to refer on to other agencies and communicate effectively with clients and other health professionals about such care.

University education has a part to play in thinking about the role of the midwife in both an historical and contemporary context. Students need to be clear that the role has changed over time in line with overall health and midwifery-specific policies. They also need to be taught to reflect on what their role should be in tackling inequalities in health and in health care provision.

We explored earlier how implications drawn from the broad sociological and social policy input on inequalities were not always applied specifically to midwifery practice. This has obvious repercussions for providing guidance in the university context as to what role midwives should play in addressing such inequalities. There were, however, a few examples of teaching sessions that considered the specific role of the midwife after exploring broad social problems. The most noticeable examples were sessions on domestic violence in Case Sites A and C; others may have occurred outside of the fieldwork periods. However, participant observation and interview data suggest that the midwife's role in relation to these issues was rarely addressed explicitly.

The terms 'referral' and 'teamwork' were mentioned many times by participants in the context of the midwife's role. Furthermore, there was ample evidence of lecturers and session leaders from other disciplines coming into the classroom to teach. Examples from the case studies include a sex therapist, medical consultants from specialisms such as obstetrics and psychiatry, and domestic violence workers. What was perhaps lacking was an analytic perspective on different models of teamwork. How the implicit use of different models by practitioners affect relationships between colleagues is important. In turn, how this impacts on what happens in relation to the care of individual clients is worthy of serious analysis. The work of Freeman et al. (2000) on philosophies of multiprofessional teamworking, discussed earlier, could be usefully drawn on to further understanding in the midwifery context.

These issues concerning perceptions of midwives' roles in relation to those of other health care workers are also important when considering how service users' perceptions of care were covered in the curriculum. Case site analyses demonstrated that how service users construct the role of their midwife has a significant bearing on the degree to which they engage with her. There is ample evidence to suggest that practitioners who work with clients in a way that avoids pathologising them have a greater chance of effecting change (Cunningham and Henggeler, 1991). It is imperative that student midwives are taught to analyse the different ways in which clients may perceive them *vis-à-vis*, for example, health visitors, social workers and other midwives.

Time management in relation to the rights, needs and demands of different clients is an important topic which warrants more explicit and systematic consideration within the educational context. This discussion could usefully be framed within the context of health care rationing. If midwives are to comply with the thrust of *Making a Difference* (DoH, 1999a), educators must emphasis the rights of disadvantaged clients to receive more targeted care, even though they may not demand it. There was little evidence in the case studies of lecturers emphasising the rights of more disadvantaged clients. Furthermore, analysis of interview data showed that educators often had very vague notions of client 'needs'. Since this is one of the concepts at the heart of the notion of individualised care it is imperative that further attention is paid to it.

### 9.4.3.2 Exploring the role in the practice setting

In interviews with midwives and students they were asked to reflect on care delivery to individual clients who they considered to experience inequalities. This provoked discussion of what the midwife could and could not do, how far the role extended, and when to refer to, and liaise with, other professionals. Accounts ranged from the positive, where midwives felt they had been able to deliver a high standard of care to a client experiencing constellations of disadvantage, to feelings of hopelessness and frustration at not being able to deliver the care they deemed appropriate.

Midwives commonly described their work with disadvantaged clients in terms of advocacy. This was also reflected in interviews with service users, many of whom explained how midwives advocated for them in relation to benefits and/or housing problems. Students also recounted observing and assisting midwives in these kinds of roles. In general, most midwives seemed happy to engage in these routine advocacy tasks on behalf of disadvantaged clients. However, whilst clients clearly felt supported by this type of advocacy, there was little evidence of such input having made a material difference to women's lives, at least in the short term. This area requires further research, especially within the context of the debates about the midwife's role. Another issue related to advocacy that arose concerned midwives' working relationships with dedicated health advocates. Here, there was often a tension concerning the roles and responsibilities of the two professional groups. There seems to be a need for increased educational input on how to manage this complex three-way relationship.

In contrast to the emphasis placed on the advocacy role of midwives, few spoke of their role in terms of health promotion. For example, few participants mentioned the issue of the midwife's role in relation to promoting breastfeeding or encouraging smoking cessation amongst disadvantaged clients. As discussed earlier, there was little input on this in the university setting and, therefore, it is not surprising to find again, little discussion of this in relation to the midwife's role. As a result it may be that students were deprived of role models in this important area. Improving midwives' skills with regard to tackling these sometimes uncomfortable and controversial health promotion issues might result in improved outcomes for service users, and, in turn, in greater job satisfaction for those midwives who express frustrations at their inability to effect change. There is much scope for development in the area of effective and appropriate health promotion education.

Another issue that arose in relation to the midwife's role concerns the question of targeting of disadvantaged clients. Whilst no participants denied that disadvantaged service users needed midwifery input, there were many differences of opinion regarding what form that input should take, and the degree to which disadvantaged clients should be prioritised over others. This was as much a feature of interviews with managers as with midwives, who clearly had less scope to effect changes in the allocation of resources. If the vision espoused by recent Government policy documents is to be realised, roles and resources within midwifery need to be more explicitly orientated towards disadvantaged clients, particularly those experiencing constellations of disadvantage. However, in the context of current resourcing, it should be recognised that increasing input to some clients will, necessarily, result in less input for others. This would be a break with the past where some of the most prominent service user lobbies within maternity care, such as the National Childbirth Trust, have been more in tune with the wants and needs of more educated and/or affluent clients. Such groups and individuals may prove resistant to changes which de-prioritise their needs.

#### 9.4.3.3 Developmental implications

The developmental implications of our findings regarding the role of the midwife, are as follows:

- the 'midwife's role' should incorporate clear targets for addressing inequalities in health, whilst allowing the practitioner to work in a flexible and creative way to help achieve these targets
- increased exploration and reflection on the role of the midwife in relation to addressing inequalities in health, in classroom and practice environments are needed
- specific attention should be paid to the midwife's role in modules addressing inequalities in health issues
- increased preparation regarding multiprofessional teamworking is needed

- educational input, in both classroom setting and practice placements, on working alongside health advocates should be increased
- educational input, in both classroom setting and practice placements, on the role of health promotion in midwifery should be increased.

## 9.5 Methods of educational delivery

It is has long been recognised that methods of educational delivery are fundamental in affecting the type and depth of students' learning (Pask, 1976; Marton and Saljo, 1976; Brockbank and McGill, 1998). With regard to the present study, it is clearly imperative that appropriate methods of teaching are promoted which reflect an holistic approach to learning, incorporating knowing, feeling and doing in order to develop students' inequalities imagination. Students need the help and encouragement of educationalists in order to change their learning styles according to the goal or context of the learning (Miller et al., 1994). Knowles' (1984) description of adult learning reminds us of the importance of students' prior learning and experience, which forms the basis of their acquisition of new knowledge and expertise. Learning methods such as problem-based learning (PBL) enable students to actively contribute their knowledge and experience in order to frame/reframe and solve real-life problems in a holistic manner (see Fraser et al., 1998; Thomas et al., 1998). However a variety of learning methods, particularly those with an experiential base, such as responding to material presented through video clips, role play, simulation of frequently encountered practice situations, are required to complement more formal methods and enhance students' learning potential. More innovative methods such as exercises in guided imagery can be used to tap experiential memories to stimulate discussion, enable their exploration at a conceptual level and help create possibilities for new action (Tuyn, 1994). The desired outcome in all these methods is to help the student to identify with the learning at an intellectual and emotional level, recognise the effect it may have on her behaviour and way of doing things and be aware of the potential for advocating it to others (Steinaker and Bell, 1979).

### 9.5.1 Educational delivery in the classroom

It was clear from the curriculum analysis and from in-depth case site work that a range of teaching methods were employed in delivering midwifery education in relation to inequalities issues, ranging from large group lectures and seminars to individual tutorials. In Case Site C extensive use was made of problem-based learning which utilised the small group work approach despite student cohorts being relatively large. However, in general, splitting up classes into small groups was not a dominant feature of the teaching sessions observed. Analysis suggests that, across most of the classes observed, irrespective of size, lecturers largely orchestrated discussion. This tended to produce a question-answer type of discussion between the lecturer and certain more vocal students. This type of teaching has the obvious advantage of giving the lecturer a great degree of influence over what is discussed. Furthermore, it may potential enable lecturers to manage the sensitive challenging of students from a 'central' position. However, little challenging of students by lecturers was observed. Increased use of small group or pair work in which lecturers circulate round the group may give the opportunity for them to challenge students in a less threatening environment. Furthermore, students may also feel more able to challenge each other in such settings.

In both feedback sessions and in focus group discussions, participants readily debated and challenged each other's views and our own in relation to inequalities in health. This may have been partly because of the perceived differences in power dynamics between participants and researchers than between students and lecturers. However, it may have had more to do with the manner in which the focus groups and feedback sessions were designed and facilitated, making extensive use of pair and small group work, handouts, flip charts and 'stickit' notes. Thus our research suggests that there is scope for lecturers to choose methods and teaching aids which are more effective for bringing about the outcomes required.

One potential way forward, which builds on the creative use of one's imagination is to make more use of dramatic reconstruction as a device for developing students' skills in dealing with challenging situations. Baker et al. (1997) have piloted the use of forum theatre to help midwifery students process events that occur in complex situations. Forum theatre is the brainchild of Boal (1979):

> *'First the participants are asked to tell a story containing a political or social problem or difficult situation. Then a 10- or 15-minute sketch portraying that problem and the solution intended for discussion is improvised or rehearsed, and subsequently presented. When the sketch is over, the participants are asked if they agree with the solution presented. At least some will say no. At this point it is explained that the scene will be performed once more … but now any participant in the audience has the right to replace any actor and lead the action in the direction she/he feels is right.'* (Boal, 1979: 139)

Such methods may be used to help students to process material specifically about disadvantaged women's lives and thus help develop their inequalities imagination. Material which helps students to understand more about disadvantaged women's lives needs to be an important part of curriculum content. In addition to dramatic reconstruction, this can be achieved in a variety of ways, and several important strategies were identified within the study. One of these was the incorporation of service users and/or service user representatives as teachers or contributors to teaching sessions. This was particular popular with students.

Educators planning to augment the role of users on their programmes should be mindful of the power issues involved. Hastings (2000) advocates for user involvement in all stages of planning and running professional care education, including assessment, rather than token involvement for one-off sessions. Furthermore, she emphasises that they should be properly paid. In her work, ways of developing user involvement in the classroom setting, including training and support for service user educators, are discussed.

Video programmes were used as tools in the teaching of inequalities issues. Examples ranged from midwifery-specific programmes to more general documentaries such as *Dispatches* on domestic violence. However, there was also evidence of an imbalance of time spent watching programmes and discussing the issues the programmes raised. For example, the programme on domestic violence, whilst aptly illustrating women's experiences, could have been used much more sparingly, leaving more time to explore midwives' communication and attitudes in relation to domestic violence via role play and small group work.

Again in relation to teaching aids, the use of information technology did not go beyond basic word-processing. In none of the teaching sessions observed were any references made to exploring issues on websites. Given the extent of material available on the web, particularly in relation to research and current health and social policy, this is now a major lacuna. There is considerable scope for the incorporation of websites onto reading lists and for discussion within the classroom. Of course, such teaching aids presume the availability of computing resources, and assumes basic computing skills, which may be more of a challenge to students on post-registration programmes.

## 9.5.2 Educational delivery in practice

Practice education is the arena in which students have the opportunity to make sense of what they have learnt in the classroom, consolidate their learning and further their knowledge in practice situations. Thus, interaction with clients and observing midwives interacting with clients is the dominant method of learning about issues of inequality.

Preceptorship of students by practising midwives is one of the main methods of educational delivery in the practice setting. Evidence from our research suggests that this can work effectively, with both students and preceptors reporting that they learnt from each other. However, as discussed earlier, across the case sites, there was a shortage of appropriately qualified preceptors, which resulted in some students having periods of time without a preceptor or a lack of continuity of preceptor. This issue clearly needs to be addressed urgently.

With increasing attention being placed on the prioritising of disadvantaged clients, the preceptor role will have to reflect this priority. This will necessitate the appropriate training and updating of preceptors in issues related to inequalities in health.

A recurring issue in midwifery education is the perceived, and sometimes actual, lack of integration between classroom and practice settings which can undermine the effective implementation of innovative teaching and learning methods. Our study identified some practices which appeared to reduce the education-practice gap. However, responsibility for this seemed to fall on educators rather than service providers. For example, there was evidence of lecturers working within practice environments in all case sites. In Case Site A, lecturer-practitioners took the main responsibility for facilitating integration between university-based learning and that occurring in practice. In Case Site B, the link lecturer scheme was prominent, with lecturers clearly playing a support role, as opposed to working alongside midwives in practice. In Case Site C they emphasised their own needs to maintain practice skills and experience. Across all case sites, students expressed the opinion that the theory-practice gap was reduced when lecturers had recent or ongoing practice experience. In this sense, it was almost as though lecturers' credibility was improved through their practice experience.

However, despite the overwhelming perception that practice experience makes for better teaching, there was no evidence to support this in relation to inequalities issues, specifically. Indeed, whilst such experience should make for better teaching in this field, it would not necessarily do so, because, as demonstrated in the case sites, not all midwives practising in areas of, for example, high socio-economic deprivation, have a well-developed inequalities imagination.

### 9.5.3 Developmental implications

The developmental implications of the findings regarding methods of educational delivery are as follows:

- use of small group work to provide a safe environment in which attitudes can be challenged sensitively should be increased
- use of innovative teaching methods, e.g. dramatic reconstruction of events should be increased
- involvement of disadvantaged service users and/or their representatives in the education of midwives should be increased
- there should be more appropriate use of teaching tools such as video programmes
- critical use of information technologies such as the Internet should be encouraged and supported
- collaboration between education and service providers with equal responsibility for so doing should be increased.

## 9.6 Assessment

The overall findings, from both the curriculum and case site analyses, suggest that inequalities issues were widely addressed in the module aims, content and learning outcomes of most midwifery curricula. However, it was less common to find such issues embedded as a compulsory part of the assessment programme. This section discusses the university and practice settings together, because whilst most attempts to assess inequalities issues were in relation to practice, there was often the assumption that such assessments would be informed by theoretical concepts and approaches acquired in the university setting. Similarly, it was assumed that students would draw on practice to illustrate points being made about inequalities issues in more theoretical, essay-based assignments.

In Case Site A, more attention appeared to be paid to assessing inequalities issues in practice, through the use of practice competencies, than through written assignments such as essays set by university lecturers. There was, for example, evidence that key attitudes contained in clinical competence statements were assessed formally. However, as many participants pointed out, it would be expected that such assessments would draw on the material covered in theoretical modules, just as the theoretical modules required that students provide examples from practice. In Case Site B, similar statements were made about theory-practice links and assessment. Here, the role of the liaison lecturer in maintaining the necessary links with the practice arena was thought to be central.

In Case Site B, there were also 'taped assessments' which focused on clinical practice but required students to draw on theoretical and conceptual issues addressed in the university setting. These were assessed by both university lecturers and midwives/mentors in a joint oral examination. In relation to this assessment, we were told that, if students wanted to get good marks, they would *'address issues to do with the local population'*, but there was no formal requirement that they do so. There was some evidence that inequalities issues were better assessed at the post-registration level than at the pre-registration level. Here, an innovative post-registration assessment involved students demonstrating that they had initiated and implemented a change in some aspect of their practice. However, this innovation was not explicitly related to inequalities.

In Case Site C, the use of problem-based learning was thought to offer opportunities for better incorporating inequalities issues into the curriculum but, even here, only one example of a theoretical assignment was found which made specific reference to inequalities issues. Problem-based learning scenarios using 'triggers' did include inequalities issues which were addressed in the compulsory written assignment on domestic violence. Other than this, there was little evidence of inequalities issues being considered a compulsory part of assessment at this site. Instead, participants suggested that simply working in such a deprived area would ensure that students acquired the necessary knowledge and skills to meet the needs of disadvantaged clients. Thus, despite many good intentions and some innovative assessments, the evidence clearly suggested that the issues of inequalities were still not fully integrated into formal assessments. Students, in particular, remained unclear as to how important such issues were in their assessed work. Some obviously felt they could go through the programme without being assessed on inequalities issues unless they chose to do so, whilst others felt, equally strongly, that this could not happen. Thus, it became apparent that a much clearer statement was needed from programme designers and lecturers regarding the importance of inequalities issues in the curriculum as a whole and in individual assessments. As one lecturer in Case Site A admitted, *'the issue is there … [but] you have to look for it' … [as] it wouldn't hit you between the eyes'.* Coverage of such issues should be a requirement, not an optional extra in all midwifery assessment. A statement to this effect would serve two purposes. At a symbolic level, it would signal the importance of ensuring attention to inequalities issues at all stages of midwifery education and practice; it would 'hit you between the eyes'. At a practical level, it would ensure that there was no ambiguity in students' minds about the requirements of individual assessments.

Clearly, there is room for debate about whether inequalities issues should be taught and assessed in separate 'inequalities-specific' modules or be integrated throughout the curriculum. Again, there is space for creative thinking and imagination. We believe that it should not be a case of 'either-or' but of 'both'. Inequalities issues should be addressed across the board as well as in specific modules. This would give the greatest possible opportunity for students to both come to terms with key concepts and theories, in inequalities-specific modules, and to apply and evaluate such concepts and theories in the light of other important topics. It would follow from this that inequalities issues are, potentially, always relevant in assessments. Students should be encouraged to identify the ways in which key concepts and theories on inequalities and disadvantage are relevant to individual assignments or argue clearly why they are not.

### 9.6.1 Developmental implications

The developmental implications of the findings regarding assessment are as follows:

- inequalities issues should be addressed as a compulsory part of all assessments, both theoretical and practical
- a clear statement to this effect should be made in all curriculum documents to reduce scope for ambiguity amongst staff and students
- inequalities issues should be taught and assessed in 'inequalities-specific' modules and in a more integrated way across all modules in the curriculum
- students should be required to demonstrate clearly why and how inequalities issues are relevant to the topic being addressed or why they are not
- students should continue to be given the opportunity to specialise in inequalities-related issues, if they so choose
- post-registration students should be assessed on their ability both to recognise the need for, and implement, change to improve the equality of care they give. Barriers to change should also be identified.

## 9.7 Who delivers?

One important question that must be considered in relation to attaining an appropriate education for midwives concerns who delivers the education. It is unrealistic to expect everyone who is involved as a lecturer or educational facilitator to have a well-developed inequalities imagination. It should however be an ongoing process within all those involved, with an understanding that it is not something that is ever fully achieved, but that is 'always becoming', much in the way that Campinha-Bacote (1999) has suggested in relation to cultural competence. It must also be recognised that many students will bring with them components of an inequalities imagination which can be drawn on in good teaching and learning practice. Likewise, midwives may have much to learn from service users regarding developing their own inequalities imaginations.

However this is unlikely to happen unless support for such development exists at the institutional level. There was plenty of evidence of a commitment, both in curriculum content and design and in personal accounts, to developing practitioners with an understanding of inequalities. However, only rarely were the educational institutions able to clearly identify their own strategies for addressing the teaching and learning of inequalities. Indeed, in many ways, such issues emerged in a rather *ad hoc* manner without any clear sense of when, where and how such issues should be addressed. Such strategies need to be developed and made much more explicit in both education and practice settings.

### 9.7.1 Developmental implications

The developmental implications of the findings regarding who delivers education related to inequalities are as follows:

- all those involved in midwifery education and practice should be engaged in the ongoing process of developing their inequalities imagination
- obvious support and leadership for the development of inequalities imaginations is needed at an institutional level, both in education and services provision
- clear and explicit strategies which demonstrably address the teaching and learning of inequalities in both education and practice settings are needed.

## 9.8 The way forward

This chapter has attempted to bring together the main findings of our research and to examine the developmental implications of those findings for the educational preparation of midwives to meet the needs of disadvantaged clients. It is suggested that the developments be thought of, collectively, as initiatives that facilitate both student and qualified midwives in developing an inequalities imagination.

The contemporary context in both midwifery services and midwifery education presents both opportunities and threats for such a development. With regard to services, on the one hand, practitioners complain of high stress, low self-esteem, ever-decreasing resources and institutionalised inequalities such as racism and sexism. On the other hand, moves have been made towards prioritising the needs of disadvantaged service users, addressing structural inequalities and changing the power dynamics between different members of the multiprofessional team.

In the university setting, tutors are faced with ever-increasing student numbers, problems with retention and recruitment and increasing demands to demonstrate effectiveness. It is clear that educators from both midwifery services and university educational provision are not currently facilitating appropriate practice placements which would help develop in students an inequalities imagination. Lecturers are being encouraged to teach larger groups in order to process larger numbers of students through the system with greater efficiency. However, there is scope within the educational environment to develop innovation in teaching and learning. Furthermore, within schools of nursing and midwifery, those with skills and experience in research and evidenced-based teaching are growing. There is also, through the commissioning of research such as this, evidence of an increasing commitment to addressing issues of inequality and discrimination in this context.

Nevertheless, there is no significant evidence to suggest that the findings of related research which has highlighted the lacunae in nursing and midwifery education in relation to issues of inequality have been widely implemented (Gerrish et al., 1996; Neile, 1997a; 1997b). Of course midwives cannot do this in isolation, and the developmental implications do not solely apply to those working directly in midwifery practice and or delivering midwifery education. They are also of major relevance to nursing and other professions within health and social services. It is also directed at the NHS, universities, educational consortia and policy-forming bodies such as the Board and the Royal College of Midwives, who need to commit resources and energy to facilitate the cultural change necessary if individuals at all levels of the hierarchy within these institutions are to develop inequalities imaginations. Strong leadership, with high-profile role modules who demonstrate by example their commitment to promoting equality of care is needed if the issue is to move beyond the level of rhetoric.

These discussions may seem far from the reality of daily service provision and disadvantaged women's experiences of pregnancy and childbirth. To end this report then, it seems appropriate to return to the voices of the service users interviewed. Rosalyn, a woman who felt she had not been given the help she needed to breastfeed her baby said:

> *'I really wanted to breastfeed and there was very little help with that … I know when you are starting to help somebody to breastfeed it takes time but they didn't have the time. When I did ask they came and just got my nipple and shoved it in her mouth and then left. I didn't like that, being handled in that way. It was quite worrying because I really didn't want to give [baby] a bottle. I know it's [trust] policy to breastfeed but in my room there was only me and one other woman who went through who were actually breastfeeding.'* (Rosalyn, client)

Becky was one of the many clients who emphasised how much she appreciated the way her midwife made her feel special and relaxed in her company:

> *'That was nice to have that personal touch, like she really cared. It was good that way, and I think a sense of humour is important.'* (Becky, client)

Midwives often expressed the feeling that there was nothing they could achieve for clients who lived in difficult circumstances. However, service users interviewed obviously did not always share this perspective. Sally, a woman experiencing constellations of disadvantage, when asked who supported her in her pregnancy, said:

> *'I didn't get no support until a couple of months. The only support I got was off them midwives ... I didn't trust any of them at first but Penny, she made me feel dead comfortable. The last few days that she was coming I was down, crying my eyes out, I was just about to give birth and my dole money hadn't come. She came to see me and sat with me.'* (Sally, client)

At face value, it may seem that it did not take much on the part of the midwife for Sally to feel supported. However, Sally's midwife had clearly put in energy and used her imagination to decide how best to care for Sally. Although she did not effuse about her midwife it was obvious that this targeted visit from a midwife who had a well-developed inequalities imagination did make a difference to the way Sally was feeling in such a desperate situation. Making a difference is certainly a challenge for those of us working in the NHS. However, if we use our imagination, it is really not impossible.

## FULL LIST OF DEVELOPMENTAL IMPLICATIONS

### Curriculum design and planning

- There should be a 'champion' on inequalities issues in the curriculum design and planning team.
- Representatives with a sociology disciplinary background should be on curriculum design and planning teams.
- Greater involvement of disadvantaged service users and representatives is needed in curriculum design and planning.
- The placing and timing of broad sociological/social policy modules used to introduce inequalities issues should be reviewed.
- A midwifery lecturer should take responsibility for facilitating students to understand the links between generic inequalities and midwifery practice from the beginning of the programme.

### Knowledge of disadvantaged women's lives

- More theoretical input is required on women living in poverty to match client group need.
- Experiential knowledge of working with disadvantaged clients should be made compulsory.

Imaginative ways of overcoming resource constraints implied by the latter suggestion include:

- swapping of placements between students
- student visits to projects dedicated to specific client groups
- making more use of disadvantaged clients in classroom learning
- making more use of the hospital placements as learning environments, especially where there are dedicated wards for specific client groups

- development of a teaching and learning package relating to service provision for disadvantaged service users in the local context
- use of this teaching and learning package with all pre-registration students
- development of a similar package as part of induction for all newly contracted midwives.

## Attitudes and communication

- Increased commitment is needed amongst all those in midwifery education and practice to developing self-awareness.
- Increased commitment to gaining skills in challenging attitudes of peers, colleagues and service users is needed.
- Methods for reflection on attitudes and communications skills should be improved by introducing more structured approaches to reflection that specifically aim to address disadvantaged clients and inequalities in health.
- Innovative methods to better equip midwives with skills and confidence to encourage service users to change health-threatening behaviours, e.g. use of actors for drama re-enactment should be developed.
- All students should be provided with appropriately-qualified and updated preceptorship in both community and hospital settings.

## Role of the midwife

- The 'midwife's role' should incorporate clear targets for addressing inequalities in health, whilst allowing the practitioner to work in a flexible and creative way to help achieve these targets.
- Increased exploration and reflection on the role of the midwife in relation to addressing inequalities in health, in classroom and practice environments are needed.
- Specific attention should be paid to the midwife's role in modules addressing inequalities in health issues.
- Increased preparation regarding multiprofessional teamworking is needed.
- Educational input, in both classroom setting and practice placements, on working alongside health advocates should be increased.
- Educational input, in both classroom setting and practice placements, on the role of health promotion in midwifery should be increased.

## Methods of educational delivery

- Use of small group work to provide a safe environment in which attitudes can be challenged sensitively should be increased.
- Use of innovative teaching methods, e.g. dramatic reconstruction of events should be increased.
- Involvement of disadvantaged service users and/or their representatives in the education of midwives should be increased.
- There should be more appropriate use of teaching tools such as video programmes.
- Critical use of information technologies such as the Internet should be encouraged and supported.
- Collaboration between education and service providers with equal responsibility for so doing should be increased.

## Assessment

- Inequalities issues should be addressed as a compulsory part of all assessments, both theoretical and practical.
- A clear statement to this effect should be made in all curriculum documents to reduce scope for ambiguity amongst staff and students.
- Inequalities issues should be taught and assessed in 'inequalities-specific' modules and in a more integrated way across all modules in the curriculum.
- Students should be required to demonstrate clearly why and how inequalities issues are relevant to the topic being addressed or why they are not.
- Students should continue to be given the opportunity to specialise in inequalities-related issues, if they so choose.
- Post-registration students should be assessed on their ability both to recognise the need for, and implement, change to improve the equality of care they give. Barriers to change should also be identified.

## Who delivers education related to inequalities?

- All those involved in midwifery education and practice should be engaged in the ongoing process of developing their inequalities imagination.
- Obvious support and leadership for the development of inequalities imaginations is needed at an institutional level, both in education and services provision.
- Clear and explicit strategies which demonstrably address the teaching and learning of inequalities in both education and practice settings are needed.

# REFERENCES

Ahmad, W.U.I. and Husband, C. (1993) Religious identity, citizenship and welfare: the case of Muslims in Britain. *American Journal of Islamic Social Sciences*, 10, 3, 217-233.

Allmark, P. (1995) A classical view of the theory-practice gap in nursing. *Journal of Advanced Nursing*, 22, 18-23.

Argyris, C. (1993) On the nature of actionable knowledge. *The Psychologist*, January, 29-32.

Association of Radical Midwives (1999) *A Vision for Midwifery Education*. Ormskirk: ARM.

Audit Commission (1997) *First Class Delivery: Improving maternity services in England and Wales*. Abingdon: Audit Commission Publications.

Backman, L., Arnetz, B.B., Levin, D., Lublin, A. et al. (1997) Psychophysiological effects of mental imaging training for police trainees. *Stress Medicine*, 13, 43-48.

Baker, K. (1999) Young, pregnant ... and pleased. *The Practising Midwife*, 2, 3, 14-16.

Baker, K., Garrett, E., Kirkham, M. (1997) The use of actresses in midwifery education: beyond role play towards learning with women. *Modern Midwife*, 7, 7.

Barbour, R. (1998) Engagement, representation and presentation in research practice. In: Barbour, R. and Huby, G. (eds) *Meddling with Mythology: AIDS and the social construction of knowledge*. London: Routledge.

Barry, C., Britten, N., Barber, N. et al. (1999) Using reflexivity to optimise teamwork in qualitative research. *Qualitative Health Research*, 9, 1, 26-44.

Bartley, M., Blane, D., Davey Smith, G. (1998) *The Sociology of Health Inequalities*. Oxford: Blackwell.

Baxter, C. (1995) The case for bilingual workers within maternity services. *Changing Childbirth Update*, 4, 5-6.

Beech, B. (1991) *Who's Holding Your Baby?* London: Bedford Square Press.

Benzeval, M., Judge, K., Whitehead, M. (eds) (1995) *Tackling Inequalities in Health: An agenda for action*. London: King's Fund.

Bharj, K. and Khan, D. (1995) Pregnancy, loss and culture: responding to the need. *British Journal of Midwifery*, 3, 11, 600-602.

Bharj, K. (1995) Providing midwifery care in a multi-cultural society. *British Journal of Midwifery*, 3, 5, 271-277.

Blackburn, C. (1993) Gender, class and smoking cessation work. *Health Visitor*, 66, 3, 83-85.

Bloor, M. and McIntosh, J. (1990) Surveillance and concealment: a comparison of techniques of client resistance in therapeutic communities and health visiting. In: Cunningham-Burley, S. and McKeganey, N. (eds) *Readings in Medical Sociology*. London: Routledge.

Boal, A. (1979) *Theatre of the Oppressed*. London: Pluto.

Booth, T. and Booth, W. (1993) Power to parents. *Nursing Times*, 89, 35, 61-63.

Boud, D., Cohen, R., Walker, D. (1993) *Using Experience for Learning*. Milton Keynes: Society for Research into Higher Education/Open University Press.

Brechin, A. (2000) The challenge of caring relationships. In: Brechin, A., Brown, H., Eby, M. (eds) *Critical Practice in Health and Social Care*. Milton Keynes: Open University Press.

Brechin, A., Brown, H., Eby, M. (eds) (2000) *Critical Practice in Health and Social Care*. Milton Keynes: Open University Press.

Brockbank, A. and McGill, I. (1998) *Facilitating Reflective Learning in Higher Education*. Milton Keynes: Society for Research into Higher Education and Open University Press.

Bryce, R. (1990) Social and midwifery support. *Clinical Obstetrics and Gynaecology*, 4, 1, 77-87.

Buber, M., (1979) *Eu E Tu*. São Paulo, Brazil: Cortez/Moraes, quoted in Sadala, M.L.A. 1999 Taking care as a relationship: a phenomenalogical view. *Journal of Advanced Nursing*, 30, 4, 808-817.

Campbell, J.C. and Campbell, D.W. (1996) Cultural competence in the care of abused women. *Journal of Nurse Midwifery*, 41, 6, 457-462.

219

## References

Campinha-Bacote, J. (1999) A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, **38**, 5, 202-207.

Cardale, P. (1992) Springing the poverty trap. *Nursing Times*, **88**, 29, 66-67.

Carstairs, V. (1991) The Jarman Index. *British Medical Journal*, **302**, 6777, 661.

Central Council for Education and Training in Social Work (1994) *Review of the Diploma in Social Work* (Consultation Paper). London: CCETSW.

Chadwick, J. (1994) Perinatal mortality and ante-natal care. *Professional Midwife*, 4, 9, 18-20.

Chesney, M. (1995) The importance of cultural beliefs. *British Journal of Midwifery*, 3, 5, 268-271.

Chesney, M. (2000) A three-way relationship. In: Kirkham, M. (ed.) *The Midwife-Mother Relationship*. London: Macmillan.

Collington, V. (1998a) Midwives as educators: perceptions of changing role. *British Journal of Midwifery*, **6**, 8, 487-496.

Collington, V. (1998b) Do women share midwives' views of their educational role? *British Journal of Midwifery*, **6**, 9, 562-563.

Cooney, A. (1999) A reflective practice. Reflection demystified: answering some common questions. *British Journal of Nursing*, **8**, 22, 1530-1534.

Cope, P., Cuthbertson, P., Stoddart, B. (2000) Situated learning in the practice placement. *Journal of Advanced Nursing*, **31**, 4, 850-856.

Crafter, H. (1997) *Health Promotion in Midwifery: Principles in practice*. London: Arnold.

Cross, G. (1994) The right to choose. *Nursing Times*, **90**, 39, 61-62.

Cruickshank, J.K. and Beevers, D.G. (1989) *Ethnic Factors in Health and Disease*. London: Butterworth-Heinemann.

Cunningham, P.B. and Henggeler, S.W. (1991) Engaging multi-problem families in treatment: lessons learned through the development of multi-systemic therapy. *Family Processes*, **38**, 265-281.

Davies, J. (1992) Against the odds. *Nursing Times*, **88**, 44, 29-31.

Davies, J. (1997) Them and us: poverty, deprivation and maternity care. In: Kargar, I. and Hunt, S. (eds) *Challenges in Midwifery Care*. London: Macmillan.

Davies, J. (2000) Being with women who are economically without. In: Kirkham, M. (ed.) *The Midwife-Mother Relationship*. London: Macmillan.

De Konig, K. and Martin, M. (1996) *Participatory Research in Health: Issues and experiences*. London: Zed Books.

Department of Health (1991) *Care Management and Assessment: Practitioner's guide*. London: HMSO.

Department of Health (1993) *Changing Childbirth Part 1: Report of the Expert Maternity Group*. London: HMSO.

Department of Health (1998a) *Supporting Families: A consultation document*. London: HMSO.

Department of Health (1998b) *Our Healthier Nation*. London: HMSO.

Department of Health (1998c) *Independent Inquiry into Inequalities in Health Report*. London: HMSO.

Department of Health (1999a) *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*. London: HMSO.

Department of Health (1999b) *Clinical Governance: Quality in the new NHS*. London: HMSO.

Department of Health (2000a) *The NHS Plan*. London: HMSO.

Department of Health (2000b) *A Health Service for all Talents: Developing the NHS workforce*. London: HMSO.

Department of Health and Royal College of Midwives (1998) HIV *Testing in Pregnancy: Information for midwives*. London: DoH and RCM.

Department of Health and Royal College of Midwives (2000) *Hepatitis B Testing in Pregnancy: Information for midwives*. London: DoH and RCM.

Department of Health and Social Security (DHSS) (1980) *Inequalities in Health: Report of a Research Working Group*. London: HMSO.

Dimond, B. (1999) The midwife and her caseload. *British Journal of Midwifery*, 7, 3, 141-143.

Dixon, K. (1997) Practical tips for supporting pregnant women with learning disabilities. *MIDIRS Midwifery Digest*, 7, 1, 40-42.

Dominelli, L. (1996) Deprofessionalising social work: anti-oppressive practice, competencies and postmodernism. *British Journal of Social Work*, 26, 2, 153-175.

Dominelli, L. (1997) *Sociology for Social Work*. Basingstoke: Macmillan.

Dopson, L. (1990) Happy alternatives. *Nursing Times*, 86, 10, 40-42.

Dunkley, J. (1997) Training midwives to help pregnant women stop smoking. *Nursing Times*, 93, 5, 64-66.

English National Board for Nursing, Midwifery and Health Visiting (1997) *Standards for Approval of Higher Education Institutions and Programmes*. London: ENB.

Eraut, M. (1994) *Developing Professional Knowledge and Competence*. Brighton: Falmer Press.

Eraut, M., Alderton J., Boylan A., Wraight, A. (1995) *Learning to Use Scientific Knowledge in Education and Practice Settings*. London: ENB.

Fealy, G.M. (1997) The theory-practice relationship in nursing: an exploration of contemporary discourse. *Journal of Advanced Nursing*, 25, 5, 1061-1069.

Festinger, L. (1962) *Theories of Cognitive Dissonance*. London: Tavistock Publications.

Fielding, N. (1993) Qualitative interviewing. In: Gilbert, N. (ed.) *Researching Social Life*. London: Sage.

Fish, D. and Purr, B. (1991) *An Evaluation of Practice-based Education in Continuing Professional Education in Nursing, Midwifery and Health Visiting* Project Paper 4. London: ENB.

Folwell, K. (1995) Single measures of deprivation. *Journal of Epidemiology and Community Health*, 49, S2, 51-56.

Fraser, D., Murphy, R., Worth-Butler, M. (1998) *Preparing Effective Midwives: An outcome evaluation of the effectiveness of pre-registration midwifery programmes of education*. London: ENB.

Freeman, M., Miller, C., Ross, N. (2000) The impact of individual philosophies of teamwork on multi-professional practice and the implications for education. *Journal of Interprofessional Care*, 14, 3, 237-247.

Garcia, J. (1982) Women's views of antenatal care. In: Enkin, M. and Chalmers I. (eds) *Effectiveness and Satisfaction in Antenatal Care*. London: Spastics International Medical Publications/ Heinemann Medical Books.

Gerrish, K., Husband, C., Mackenzie, J. (1996) *Nursing for a Multi-ethnic Society*. Milton Keynes: Open University Press.

Gerrish, K., McManus, M., Ashworth, P. (1997) *Levels of Achievement: A review of the assessment of practice*. London: ENB.

Giddens, A. (1984) *The Constitution of Society*. Cambridge: Polity Press.

Glaser, B. and Strauss, A. (1965) *The Awareness of Dying*. Chicago Il: Aldine.

Gould, N. and Harris, A. (1996) Student imagery of practice in social work and teacher education: a comparative research approach. *Journal of Social Work*, 26, 2, 223-237.

Graham, H. (1987) Women's smoking and family health. *Social Science and Medicine*, 25, 1, 47-56.

Graham, H. (1993) Women smoking: government targets and social trends. *Health Visitor*, 66, 3, 80-82.

Graham, H. (2000) Understanding health inequalities. *MIDIRS Midwifery Digest*, 10, 2, 144-148.

Gray, M. and Smith, L. (1999) The professional socialisation of diploma of higher education in nursing students (Project 2000): a longitudinal qualitative study. *Journal of Advanced Nursing*, 29, 3, 639-647.

Gregg, P., Harkness, S. Machin, S. (1999) *Child Development and Family Income*. York: Joseph Rowntree Foundation.

Hall, M., Chng, P.K., MacGillivray, I. (1980) Is routine ante-natal care worth while? *Lancet*, ii, 8185, 78-80.

Hart, A. (1995a) *Female Sex Worker Needs Assessment*. Brighton: East Sussex Health Authority.

Hart, A. (ed.) (1997) *An Evaluation of Team Midwifery: The Impact on women, practitioners, practice*. Brighton Health Care NHS Trust.

Hart, A. (1998) *Buying and Selling Power: Anthropological reflections on prostitution in Spain*. Boulder, Co: Westview Press.

**References**

Hart, A. and Pankhurst, F. (1998) *The Impact of Nurse Led Drug Administration (NLDA) and Pharmacy Prescribing (PP) on Junior Doctors' Work: A pilot study*. Brighton Health Care NHS Trust.

Hart, A., Pankhurst, F., Sommerville, F. (1999) Not enough pros, too many cons. Findings of an evaluation of team midwifery. *British Journal of Midwifery*, 7, 9, 573-578.

Hastings, M. (2000) User involvement in education and training. In: Pierce, R. and Weinstein, J. (eds) *Innovative Education and Training for Care Professionals: A providers' guide*. London: Jessica Kingsley.

Hodnett, E.D. and Roberts, I. (1997) Home-based support for socially disadvantaged mothers. *The Cochrane Library*, 1998: Issue 1.

Holmes, V. (1997) Grading journals in clinical practice: a delicate issue. *Journal of Nursing Education*, 36, 10, 489-492.

Home Office (1998) *Supporting Families: A consultation document*. London: HMSO.

House of Commons Social Services Committee (1980) *Perinatal and Neonatal Mortality Second Report*. London: HMSO.

House of Commons Health Select Committee (1992) *Second Report: Maternity services*. London: HMSO.

Howarth, C., Kenway, P., Palmer, G., Miorelli, R. et al. (1998) *Monitoring Poverty and Social Exclusion: Labour's inheritance*. York: Joseph Rowntree Foundation.

Hunt, S.C. and Symonds, A. (1995) *The Social Meaning of Midwifery*. London: Macmillan.

Hunter, D. (1998) The new health policy agenda: the challenge facing managers and researchers. *Research, Policy and Planning*, 16, 2, 2-6.

Jacob, S. and Watson, P. (1998) Relevance of clinical placements from a student perspective. *RCM Midwives Journal*, 1, 6, 180-181.

Jarvis, P. (1992) Reflective practice and nursing. *Nurse Education Today*, 12, 174-181.

Jenkins, R. (1995) Midwifery: a matter of politics. In: Murphy-Black, T. (ed.) *Issues in Midwifery*. Edinburgh: Churchill Livingstone.

Jones, C. and Graham, J. (1994) The growth of management connoisseurship through reflective practice. *Journal of Nursing Management*, 2, 253-260.

Jones, K. and Macleod-Clark, J. (1993) Smoking and pregnancy: the role of health professionals. *Health Visitor*, 66, 3, 88-90.

Kaminski, M., Goujard, J., Rumeau-Roμquette, C. (1973) Prediction of low birthweight and prematurity by a multiple regression analysis with maternal characteristics known since the beginning of pregnancy. *International Journal of Epidemiology*, 2, 194-204.

Kargar, I. and Hunt, S. (eds) (1997) *Challenges in Midwifery Care*. London: Macmillan.

Kaufmann, T. (2000) Maternity care for lesbian mothers: an acid test of woman-centred care. *RCM Midwives Journal*, 3, 4, 116-117.

Keen, J. and Packwood, T. (1995) Case study evaluation. *British Medical Journal*, 311, 444-446.

Kelsall, J. (1993) Giving midwifery care for the deaf. *Midwives Chronicle*, March: 80-83.

Kelsall, J. (1997) Hearing impairment and midwifery care. In: Kargar, I. and Hunt, S. (eds) *Challenges in Midwifery Care*. London: Macmillan.

Kent, J., MacKeith, N., Maggs, C. (1994) *Direct But Different. An evaluation of the implementation of pre-registration midwifery education in England*. London: Crown Publications.

Kirkham, M. (ed.) (2000) *The Midwife-mother Relationship*. London: Macmillan.

Kirkham, M.J. and Perkins, E.R. (1997) *Reflections on Midwifery*. London: Baillière Tindall.

Knowles, M.S. (1984) *The Adult Learner: A neglected species*. Houston Tx: Gulf Publishing.

Kolb, D. (1984) *Experiential Learning: Experience as the source of learning and development*. Springfield NJ: Prentice-Hall.

Kroll, D. (1990) Equal access to care? *Nursing Times*, 86, 23, 72-73.

Lawton, D. (1983) *Curriculum Studies and Educational Planning*. London: Hodder and Stoughton.

Leach, P. (1983) *Babyhood: Infant development from birth to two years* ( 2nd edn). London: Penguin.

Lee, G. (1997) The concept of continuity, In: Mavis J. Kirkham, M.J. and Elizabeth R. Perkins, E.R. (eds) *Reflections on Midwifery*. London: Ballière Tindall.

Lee, R. (1993) *Doing Research on Sensitive Topics*. London: Sage.

Leininger, M. (ed.) (1991) *Culture Care, Diversity and Universality: A theory of nursing*. New York NY: National League for Nursing Press.

MacFarlane, A. and Mugford, M. (1999) *Birth Counts: Statistics of pregnancy and childbirth*. London: The Stationary Office.

Mackintosh, C. (1998) Reflection: a flawed strategy for the nursing profession. *Nurse Education Today*, **18**, 7, 553-7.

Mander, R. (1997) What are we called? Words that colleagues use. *British Journal of Midwifery*, 5, 7, 406.

Mander, R. (1999) Teenage pregnancy: a challenge or a problem and for whom? *Midwives Journal*, 2, 9, 280.

Marton, F., and Saljo, R. (1976) On qualitative differences in learning: outcome and process. *British Journal of Educational Psychology*, 46, 4-11.

Mason, J. (1995) Governing childbirth: the wider view. *Journal of Advanced Nursing*, 22, 835-840.

Maternity Alliance (1994a) *Disability Working Group Pack*. London: Maternity Alliance.

Maternity Alliance (1994b) *Listen To Us For a Change: A charter for disabled parents and parents to be*. London: Maternity Alliance.

Maynard, M. (1994) Methods, practice and epistemology: the debate about feminism and research. In: Maynard, M. and Purvis, J. (eds) *Researching Women's Lives From a Feminist Perspective*. London: Taylor and Francis.

McMahon, C.E. (1973) Images as motives and motivators: a historical perspective. *American Journal of Psychology*, 86, 3, 465-490.

Mercey, D. (1998) Antenatal HIV testing. *British Medical Journal*, 316, 241-242.

Miller, C.M.L. and Parlett, M. (1974) *Up To The Mark: A study of the examination game*. Slough: NFER.

Miller, C., Tomlinson, A., Jones, M. (1994) *Learning Styles and Facilitating Reflection*. London: ENB.

Miller, C., Ross, N., Freeman, M. (1999) *Shared Learning and Clinical Teamwork: New directions in education for multiprofessional practice*. London: ENB.

Miller, S. (1999) Critical incidences and the value of reflective thinking. *British Journal of Midwifery*, 7, 1, 19-22.

Mir, R. (1996) Advocate for Asian women. *MIDIRS Midwifery Digest*, 6, 1, 102-104.

Morgan, G. (1993) *Imaginization: the art of creative management*. London: Sage Pubs. Inc.

Morris, J. (1999) Making a difference in midwifery. *The Practising Midwife*, 2, 11, 30-31.

Mulligan, J. (1992) Internal processors in experiential learning. In: Mulligan, J. and Griffin, C. (eds) *Empowerment Through Experiential Learning: Explorations of good practice*. London: Kogan Page.

Murphy, F. (2000) Development of the nurse lecturer. *Journal of Advanced Nursing*, 30, 3, 704-714.

NCH Action for Children and the Maternity Alliance (1995) *Poor Expectations: Poverty and undernourishment in pregnancy*. London: NCH Action for Children and the Maternity Alliance.

Neile, E.E. (1996) Multicultural education in midwifery. *Midwifery Matters*, 71, Winter, 14-17.

Neile, E.E. (1997a) What midwives need to learn about issues of race and culture. *MIDIRS Midwifery Digest*, 7, 1, 29-33.

Neile, E.E. (1997b) Control for black and ethnic women: a meaningless pursuit? In: Kirkham, M.J. and Perkins, E.R. (eds) *Reflections on Midwifery*. London: Ballière Tindall.

*New Collins Dictionary and Thesaurus*. (1991) Glasgow: HarperCollins.

Nettledon, S. (1995) *The Sociology of Health and Illness*. Cambridge: Polity Press.

NHS Executive (1998) *Integrating Theory and Practice in Nursing. A Report commissioned by the Chief Nursing Officer/Director of Nursing*. London: DoH.

Nixon, K. (1997) Practical tips for supporting pregnant women with learning disabilities. *MIDIRS Midwifery Digest*, 7, 1, 40-42.

**References**

Nolan, M. (1998) Teenage pregnancy: a challenge for the government and nation. *RCM Midwives Journal*, 1, 5, 152-154.

Oakley, A. (1992) *Social Support and Motherhood*. Oxford: Blackwell.

Oakley, A., Rajan, L., Grant, A. (1990) Social support and pregnancy outcome. *British Journal of Obstetrics and Gynaecology*, 97, 155-162.

Ollerhead, K. (1999) Primary care trusts: new opportunities in the NHS? *The Practising Midwife*, 2, 11, 13.

Page, L. (2000) New midwifery for the millennium. *British Journal of Midwifery*, 8, 1, 8.

Pairman, S. (2000) Women-centred midwifery: partnership or professional friendship. In: Kirkham, M. (ed.) *The Midwife-mother Relationship*. London: Macmillan.

Parsons, L. and Day, S. (1992) Improving obstetric outcomes in ethnic minorities: an evaluation of health advocacy in Hackney. *Journal of Public Health Medicine*, 14, 2, 183-191.

Partlett, M. and Hamilton, D. (1977) Evaluation as illumination. In: Hamilton, D., Jenkins, D., King, C. et al. (eds) *Beyond the Number Game*. London: Macmillan Education.

Pask, G. (1976) Styles and strategies of learning. *British Journal of Educational Psychology*, 46, 128-148.

Pawson, R. and Tilley, N. (1997) *Realistic Evaluation*. London: Sage.

Pearce, B. (1989) *Communication and the Human Condition*. Southern Illinois University Press.

Polaschek, N.R. (1998) Cultural safety: a new concept in nursing people of different ethnicities. *Journal of Advanced Nursing*, 27, 452-457.

Popay, J., Williams, G., Thomas, C., Gatrell, A. (1998) Theorising inequalities in health: the place of lay knowledge. In: Bartley, M., Blane, D., Davey Smith, G. (eds) *The Sociology of Health Inequalities*. Oxford: Blackwell.

Pope, R., Cooney, M., Graham, L., Holiday, M. (1996) *Identification of the Changing Educational Needs of Midwives in Developing New Dimensions of Care in a Variety of Settings*. London: ENB.

Pope, R., Cooney, M., Graham, L., Holiday, M. (1997) Aspects of care provided by midwives 1: an overview. *British Journal of Midwifery*, 5, 12, 766-770.

Pope, R., Cooney, M., Graham, L., Holiday, M. (1998a) Aspects of midwifery care 2: 'enhanced role' and social aspects. *British Journal of Midwifery*, 6, 1, 20-24.

Pope, R., Cooney, M., Graham, L., Holiday, M. (1998b) Aspects of midwifery care 5: the continuing educational needs of midwives. *British Journal of Midwifery*, 6, 4, 266-270.

Pope, R., Cooney, M., Graham, L. Holiday, M. (1998c) Aspects of midwifery care 3: the organisation of midwifery care. *British Journal of Midwifery*, 6, 2, 88-92.

Pope, R., Cooney, M., Graham, L., Holiday, M. (1998d) Aspects of midwifery care 4: views of professionals and mothers. *British Journal of Midwifery*, 6, 3, 144-147.

Preston-Shoot, M. (1995) Assessing anti-oppressive practice. *Social Work Education*, 14, 2, 11-29.

Price, A. and Price, B. (1993) Midwifery knowledge theory for action, theory for practice. *British Journal of Midwifery*, 1, 5, 233-237.

Priestley, F. (1997) Health link. *Midwives*, 110, 1316, 215.

Rafferty, A.M., Allcock, N., Lathlean, J. (1996) The theory/practice gap: taking issue with the issue. *Journal of Advanced Nursing*, 23, 685-691.

Ramsden, I. (1995) Cultural safety: implementing the concepts. Paper presented at the Social Forces of Nursing and Midwifery Conference. Wellington: New Zealand.

Razack, N. (1999) Anti-discriminatory practice: pedagogical struggles and challenges. *British Journal of Social Work*, 29, 231-250.

Reilly, R. (1993) Homelessness: a midwifery perspective. *Midwives Chronicle*, December, 486-490.

Richards, L. (1999) Qualitative teamwork: making it work. *Qualitative Health Research*, 9, 1, 7-10.

Rose, V. (1994) Health education for parents with special needs. *Health Visitor*, 67, 3, 95-96.

Royal College of Midwives (1997) *Position Paper 19: Domestic abuse in pregnancy*. London: RCM.

Royal College of Midwives (1998) *Position Paper 16: HIV and AIDS – update*. London: RCM.

Royal College of Midwives (2000a) *Vision 2000*. London: RCM.

Royal College of Midwives (2000b) Position Paper No 22: Maternity care for lesbian mothers. *Midwives Journal*, 3, 2, 118-120.

Royal College of Midwives (2000c) Peer review. *Midwives Journal*, Supplement September.

Sadala, M.L.A. (1999) Taking care as a relationship: a phenomenological view. *Journal of Advanced Nursing*, 30, 4, 808-817.

Saffron, L. (1999) Meeting the needs of lesbian clients. *The Practising Midwife*, 2, 11, 18-19.

Salmon, D. and Powell, J. (1998) Caring for women in poverty: a critical review. *British Journal of Midwifery*, 6, 2, 108-111.

Sapsford, R. and Abbott, P. (1998) *Research Methods For Nurses and the Caring Professions*. Buckingham: Open University Press.

Sayce, L. (1998) Stigma, discrimination and social exclusion: what's in a word? *Journal of Mental Health*, 7, 4, 331-343.

Schön, D.A. (1991) *The Reflective Practitioner: How professionals think in action*. New York NY: Basic Books.

Schott, J. and Henley, A. (1996) *Culture, Religion and Childbearing: A handbook for professionals*. London: Butterworth Heinemann.

Sen, D.M., and Holmes, C. (1996) Newcastle Bangladeshi Midwifery Project. *MIDIRS Midwifery Digest*, 6, 2, 225-229.

Sheppard, M. and Woodcock, J. (1999) Need as an operating concept. *Child and Family Social Work*, 4, 67-76.

Siddiqui, J. (1994) A philosophical exploration of midwifery knowledge. *British Journal of Midwifery*, 2, 9, 419-438.

Simons, H. (ed.) (1980) Case studies in the context of educational research and evaluation. In: *Towards a Science of the Singular* CARE Occasional Publications No. 10. Norwich: University of East Anglia, Centre for Applied Research in Education.

Simpson, W., Johnstone, F., Boyd, M. et al. (1998) Uptake and acceptability of antenatal HIV testing: *British Medical Journal*, 316, 30, 4, 808-817.

Skilbeck, M. (1984) *School Based Curriculum Development*. London: Harper Row.

Smith, G. (1980) *Social Need*. London: Routledge and Kegan Paul.

Smith, G. and Cantley, C. (1985) *Assessing Health Care: A study in organisational evaluation*. Milton Keynes: Open University Press.

Smith, P. (1992) *The Emotional Labour of Nursing*. Macmillan: Basingstoke.

Social Exclusion Unit (1999) *Teenage Pregnancy: A Report by the Social Exclusion Unit*. London: The Stationery Office.

Stake, R. (1979) Program evaluation, particularly responsive evaluation. In: Dockrell, W.B. and Hamilton, D. (eds) *Rethinking Educational Research*. Sevenoaks: Hodder and Stoughton.

Steinaker, N. and Bell, R. (1979) *The Experiential Taxonomy: A new approach to teaching and learning*. New York NY: Academic Press.

Strauss, A. and Corbin, J. (1990) *Basics of Qualitative Research: Grounded theory procedures and techniques*. Newbury Park Ca: Sage.

Stuart, C. (1998) Concepts of reflection and reflective practice. *British Journal of Midwifery*, 6, 10, 640-647.

Stuart, C. (2000) A model for developing skills of reflection. *British Journal of Midwifery*, 8, 2, 111-117.

Swann, Y. (1997) Reflection, supervision and the practitioner. *British Journal of Midwifery*, 5, 8, 501.

Teasdale, K. (ed.) (1998) *Advocacy in Health Care*. London: Blackwell Science.

Tennant, J. and Butler, M. (1999) Communication: Issues for change. *British Journal of Midwifery*, 7, 6, 359-362.

Thoits, P. (1982) Conceptual, methodological and theoretical problems in studying social support as a buffer against life stress. *Journal of Health and Social Behaviour*, 23, 145-159.

Thomas, B.G., Quant, V.M., Cooke, P. (1998) The development of a problem based curriculum in midwifery. *Midwifery*, 14, 261-265.

**References**

Tishelman, C., Forss, A., Sachs, L. et al. (1999) Research on risk and risk in research: Theoretical and practical experiences from a multidisciplinary study on cervical cancer screening in urban Sweden. *Qualitative Health Research*, 9, 1, 45-60.

Tripp-Reimer, T., Sorofman, B., Peters, J., Waterman, J. (1994) Research teams: possibilities and pitfalls in collaborative qualitative research. In: Morse, J. (ed.) *Critical Issues in Qualitative Research Methods*. Thousand Oaks Ca: Sage.

Stewart, M. (1999) Lesbian parents talk about their birth experience. *British Journal of Midwifery*, 7, 2, 96-101.

Tuyn, L.K. (1994) Using guided imagery exercises in the classroom. *Journal of Nursing Education*, 33, 4, 157-158.

Tyler, S. (1994) Maternity care and the paradox of plenty. *British Journal of Midwifery*, 2, 11, 552-554.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) *Code of Professional Conduct for Nursing, Midwives and Health Visitors*. London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1993) *The Midwives' Rules*. London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1998) *The Midwives' Rules and Code of Practice*. London: UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) *Fitness for Practice*. London: UKCC.

Ussher, J. (1997) *Body Talk: The material and discursive regulation of sexuality, madness and reproduction*. London: Routledge.

Veitch, L,. May, N., McIntosh, J. (1997) The practice based context of educational innovation: nurse and midwife preparation in Scotland. *Journal of Advanced Nursing*, 25, 191-198.

Walker, D. (1985) Writing and reflection. In: Boud, D., Keogh, R., Walker, D. (eds) *Reflection: Turning experience into learning*. London: Kogan Page.

Wasongarz, D. (1994) Bioethics and the Intermediary Role of Interpreter; Negotiating Language, Culture and Emotion. Paper Presented at the annual meeting of the American Anthropological Association. Atlanta, GA.

White, E., Riley, L., Davis, S., Twinn, S. (1993) *A Detailed Study of the Relationship between Teaching, Support, Supervision and Role Modelling for Students in Clinical Areas within the Context of Project 2000*. London: ENB.

Wilkinson, R. (1996) *Unhealthy Societies: The afflictions of inequality*. London: Routledge.

Wilkinson, R. (1997) Health inequalities relative to absolute material standards. *British Medical Journal*, 13, 591-595.

Williams, C. (1999) Connecting anti-racist and anti-oppressive theory and practice: retrenchment or reappraisal? *British Journal of Social Work*, 29, 211-230.

Williams, R. (1983) *Keywords: A vocabulary of culture and society*. London: Flamingo.

Wilton, T. (1996) Caring for the lesbian client: homophobia and midwifery. *British Journal of Midwifery*, 4, 3, 126-131.

Wood, P. and Schwass, M. (1993) Cultural safety: a framework for changing attitudes. *Nursing Praxis*, 8, 1, 4-5.

Wright, B. (1997) Pregnancy and disability: a challenge for midwives. *Maternity Action*, 78, 10-11.

Wright Mills, C. (1959) *The Sociological Imagination*. London: Penguin.

Young, M. and Wilmott, P. (1986) *Family and Kinship in East London*. London: Penguin.

# RESEARCHING PROFESSIONAL EDUCATION

## *Titles in this series*

*20* **Addressing Inequalities in Health: new directions in midwifery education and practice**
A Hart, R Lockey, F Henwood, F Pankhurst, V Hall, F Sommerville – 2001

*19* **Teamworking in Rehabilitation: exploring the role of the nurse**
A Long, R Kneafsey, J Ryan, J Berry, R Howard – 2001

*18* **Nurse Education and Communities of Practice**
I Burkitt, C Husband, J MacKenzie, A Torn, with R Crow – 2001

*17* **Teamworking in Mental Health: zones of comfort and challenge**
S Stark, I Stronach, T Warne, D Skidmore, A Cotton, M Montgomery – 2000

*16* **Practice and Assessment in Nursing and Midwifery: doing it for real**
T Phillips, J Schostak, J Tyler – 2000

*15* **Nursing and Medication Education: concept analysis research for curriculum and practice development**
S Latter, P Yerrell, J Rycroft-Malone, D Shaw – 2000

*14* **Shared Learning and Clinical Teamwork: new directions in education for multiprofessional practice**
C Miller, N Ross, M Freeman – 1999

*13* **Diversity and Complexity: a documentary analysis of critical care nursing education**
J Scholes, R Endacott, A Chellel – 1999

*12* **Evaluation of the Implementation of the Framework for Continuing Professional Education and the Higher Award**
R Owen, M Nolan, A Venables, R Behi – 1999

*11* **Preparation for the Developing Role of the Community Children's Nurse**
S Procter, S Campbell, C Biott, S Edward, with N Redpath, M Morgan – 1999

*10* **Managing and Assessing Risk in Nursing Practice: supporting vulnerable people in the community**
A Alaszewski, H Alaszewski, J Manthorpe, S Ayer – 1998

*9* **Preparing Effective Midwives: an outcome evaluation of the effectiveness of pre-registration midwifery programmes of education**
D Fraser, R Murphy, M Worth-Butler – 1998

*8* **The Role of the Teacher/Lecturer in Practice**
C Day, D Fraser, M Mallik – 1998

*7* **Recruiting Minority Ethnic Groups into Nursing, Midwifery and Health Visiting**
P Iganski, A Spong, D Mason, A Humphreys, M Watkins – 1998

*6* **New Directions in Rehabilitation: exploring the nursing contribution**
M Nolan, A Booth, J Nolan – 1997

*5* **Levels of Achievement: a review of the assessment of practice**
K Gerrish, M McManus, P Ashworth – 1997

*4* **Breaking New Ground: an exploratory study of the role and education of the advanced neonatal nurse practitioner**
M E Redshaw, A Harris – 1995

*3* **Learning to Use Scientific Knowledge in Education and Practice Settings: an evaluation of the contribution of the biological behavioural and social sciences to pre-registration nursing and midwifery programmes**
M Eraut, J Alderton, A Boylan, A Wraight – 1995

*2* **Learning Styles and Facilitating Reflection**
C Miller, A Tomlinson, M Jones – 1994

*1* **Education, Dialogue and Assessment: creating partnership for improving practice (The ACE Report)**
T Phillips, H Bedford, J Robinson, J Schostak – 1994

If you would like further details of any of these titles, please contact the Board's Publications Section at:

Victory House, 170 Tottenham Court Road, London W1T 7HA
Telephone: 020 7391 6314 Fax: 020 7383 7276 E-mail: pubs@enb.org.uk

RESEARCHING
PROFESSIONAL
EDUCATION

*A series from the English National Board for Nursing, Midwifery and Health Visiting*

# Addressing Inequalities in Health: new directions in midwifery education and practice

Angie Hart
Rachael Lockey
Flis Henwood
Francesca Pankhurst
Valerie Hall
Fiona Somerville

This report, in the Board's series *Researching Professional Education*, has been published to make Board-commissioned research readily available to policy makers, practitioners, researchers and educationalists.

Tackling health inequalities is firmly on the health agenda and this research addresses some of the key questions concerning the effectiveness of midwifery education in meeting the needs of disadvantaged clients. Among other methods the research team conducted in-depth case site interviews with student midwives, qualified midwives, educators and service users. These provide valuable insight into the perceptions of midwives and their clients.

This report has important implications, not only for the educational preparation of midwives, but also for other health professions in meeting the needs of disadvantaged clients. It is suggested that the developments be thought of, collectively, as initiatives that facilitate both students and qualified practitioners in developing an 'inequalities imagination'.

QUALITY EDUCATION · FOR QUALITY CARE ·
ENB

**English National Board for Nursing, Midwifery and Health Visiting**
Victory House, 170 Tottenham Court Road, London WIT 7HA
Telephone: 020 7388 3131 Fax: 020 7383 4031
E-mail: link@enb.org.uk Internet: http://www.enb.org.uk

CE083201 & CE083202

**U.S. Department of Education**
*Office of Educational Research and Improvement (OERI)*
*National Library of Education (NLE)*
*Educational Resources Information Center (ERIC)*

ERIC

# REPRODUCTION RELEASE

(Specific Document)

## I. DOCUMENT IDENTIFICATION:

Title: ADDRESSING INEQUALITIES IN HEALTH: NEW DIRECTIONS IN MIDWIFERY EDUCATION AND PRACTICE AND RESEARCH HIGHLIGHTS NO. 46

Author(s):

Corporate Source: ENB

Publication Date:

## II. REPRODUCTION RELEASE:

In order to disseminate as widely as possible timely and significant materials of interest to the educational community, documents announced in the monthly abstract journal of the ERIC system, *Resources in Education* (RIE), are usually made available to users in microfiche, reproduced paper copy, and electronic media, and sold through the ERIC Document Reproduction Service (EDRS). Credit is given to the source of each document, and, if reproduction release is granted, one of the following notices is affixed to the document.

If permission is granted to reproduce and disseminate the identified document, please CHECK ONE of the following three options and sign at the bottom of the page.

| The sample sticker shown below will be affixed to all Level 1 documents | The sample sticker shown below will be affixed to all Level 2A documents | The sample sticker shown below will be affixed to all Level 2B documents |
|---|---|---|
| PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL HAS BEEN GRANTED BY<br>Sample<br>TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)<br>1 | PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE, AND IN ELECTRONIC MEDIA FOR ERIC COLLECTION SUBSCRIBERS ONLY, HAS BEEN GRANTED BY<br>Sample<br>TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)<br>2A | PERMISSION TO REPRODUCE AND DISSEMINATE THIS MATERIAL IN MICROFICHE ONLY HAS BEEN GRANTED BY<br>Sample<br>TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)<br>2B |
| Level 1<br>↑<br>☐ | Level 2A<br>↑<br>☐ | Level 2B<br>↑<br>☑ |
| Check here for Level 1 release, permitting reproduction and dissemination in microfiche or other ERIC archival media (e.g., electronic) and paper copy. | Check here for Level 2A release, permitting reproduction and dissemination in microfiche and in electronic media for ERIC archival collection subscribers only | Check here for Level 2B release, permitting reproduction and dissemination in microfiche only |

Documents will be processed as indicated provided reproduction quality permits.
If permission to reproduce is granted, but no box is checked, documents will be processed at Level 1.

*I hereby grant to the Educational Resources Information Center (ERIC) nonexclusive permission to reproduce and disseminate this document as indicated above. Reproduction from the ERIC microfiche or electronic media by persons other than ERIC employees and its system contractors requires permission from the copyright holder. Exception is made for non-profit reproduction by libraries and other service agencies to satisfy information needs of educators in response to discrete inquiries.*

**Sign here,→ please**

| | | |
|---|---|---|
| Signature: O. Akinade | Printed Name/Position/Title: O. AKINADE | |
| Organization/Address: ENB, 1 VICTORY HOUSE,<br>170 TOTTENHAM COURT RD,<br>LONDON W1T 7HA | Telephone: | FAX: |
| | E-Mail Address: | Date: 13/8/02 |

(over)

## III. DOCUMENT AVAILABILITY INFORMATION (FROM NON-ERIC SOURCE):

If permission to reproduce is not granted to ERIC, *or*, if you wish ERIC to cite the availability of the document from another source, please provide the following information regarding the availability of the document. (ERIC will not announce a document unless it is publicly available, and a dependable source can be specified. Contributors should also be aware that ERIC selection criteria are significantly more stringent for documents that cannot be made available through EDRS.)

| |
|---|
| Publisher/Distributor: |
| Address: |
| Price: |

## IV. REFERRAL OF ERIC TO COPYRIGHT/REPRODUCTION RIGHTS HOLDER:

If the right to grant this reproduction release is held by someone other than the addressee, please provide the appropriate name and address:

| |
|---|
| Name: |
| Address: |

## V. WHERE TO SEND THIS FORM:

Send this form to the following ERIC Clearinghouse:

**Cheryl Grossman**
**Processing Coordinator**
**ERIC Clearinghouse on Adult, Career, and Vocational Education**
**Center on Education and Training for Employment**
**1900 Kenny Road**
**Columbus, OH 43210-1090**

However, if solicited by the ERIC Facility, or if making an unsolicited contribution to ERIC, return this form (and the document being contributed) to:

EFF-088 (Rev. 9/97)
PREVIOUS VERSIONS OF THIS FORM ARE OBSOLETE.